

3369

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY

Balto.

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS

54
00

Middle River

LENGTH OF STAY (in this place)

14 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Balto.

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN

Middle River

54

STREET ADDRESS (If rural, give location)

16 Dihedral Drive

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

TOMMIE

C.

ADCOCK

4. DATE

(Month)

(Day)

(Year)

OF

DEATH:

4-12

19 55

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

MARRIED

8. DATE OF BIRTH:

5-15-1907

9. AGE last birthday:

47 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Elect

10b. KIND OF BUSINESS OR INDUSTRY:

MANUFACTURE

11. BIRTHPLACE (State or foreign country):

ALABAMA

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME:

TOMMIE ADCOCK

14. MOTHER'S MAIDEN NAME:

HYATT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

918-05-2560

17. INFORMANT & ADDRESS:

MARY ADCOCK

SAME

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a)

DUE TO

Coronary Thrombosis

Antecedent cause(s)

(b)

DUE TO

Hypertension and A.V. Block

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 1/2 hours

four years

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

no

PLACE (Home, farm, factory, street, OF office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while M. work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from..... Jan....., 1953, to..... April....., 1955, that I last saw the deceased alive on..... March 14....., 1955, and that death occurred at..... 10 A.....m., from the causes and on the date stated above.

SIGNATURE

Wm. A. Deak

(DEGREE OR TITLE) ADDRESS

M.D.

901 Funelage on Balt. 20th

DATE SIGNED

4-13-55

23. BURIAL, CREMATION REMOVAL (Specify):

Burial

DATE THEREOF

4-15-1955

NAME OF CEMETERY OR CREMATORY

Moreland Park

LOCATION (City, town, or county)

Balto.

(State)

Md.

DATE REC'D BY LOCAL REG.

4-13-55

REGISTRAR'S SIGNATURE

A. W. Hedrick

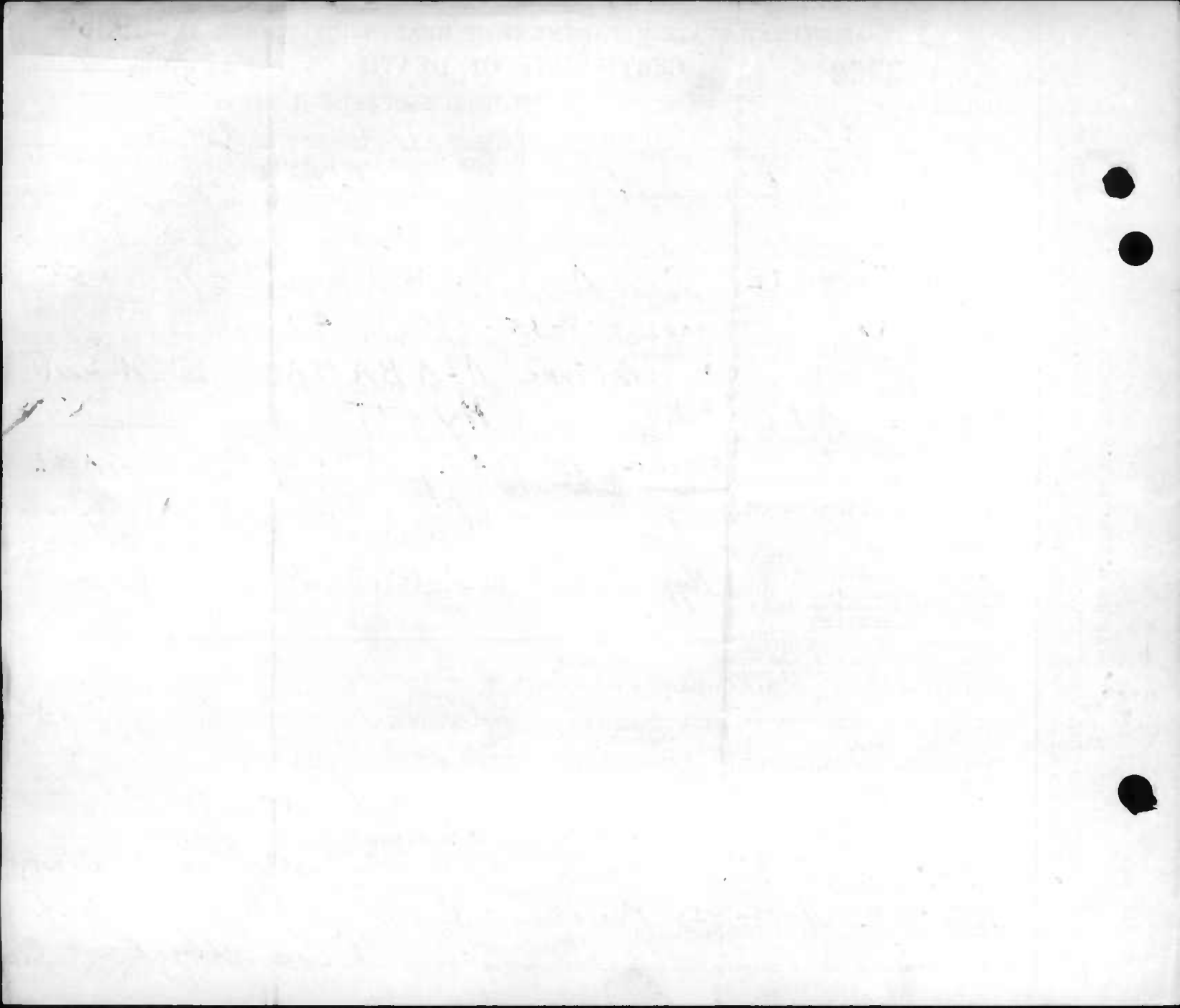
24. FUNERAL DIRECTOR

John G. Connelly, Essex Md

ADDRESS

MARGIN RESERVED FOR BINDING

(4)



3370

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 CATONSVILLE</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO., 28</u>		<u>52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>327 HARLEM LANE</u>				STREET ADDRESS (If rural give location) <u>4215 BELLVUE AVE.</u>			
3. NAME OF DECEASED: (First) <u>ANNIE</u> (Middle) <u>E.</u> (Last) <u>ALBERS</u>				4. DATE OF DEATH: (Month) <u>April</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>		8. DATE OF BIRTH: <u>OCT. 4, 1872</u>	
9. AGE last birthday: <u>72</u> yrs.		10. AGE last birthday: <u>72</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>CHARLES F. ALBERS</u>				14. MOTHER'S MAIDEN NAME: <u>ANNIE DUNKEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>HELEN L. ALBERS</u> <u>ABOVE</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Coronary Thrombosis</u>						<u>6 hrs.</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Coronary Sclerosis</u>							
(c) <u>Arteriosclerotic C-V Dis.</u>							
<u>Generalized arteriosclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1954</u> to <u>April 1955</u> , that I last saw the deceased alive on <u>March 9 1955</u> , and that death occurred at <u>April 11 5 am</u> , from the causes and on the date stated above.							
SIGNATURE <u>Kenneth Krulicich MD</u>				ADDRESS <u>400 N. Hilton St.</u> DATE SIGNED <u>4/12/55.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4-13-1955</u>		<u>LODON PARK</u>		<u>BALTO.</u> <u>MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>4-11-55</u>		<u>H. W. Jenkins & Sons Co.</u>		<u>4905 YORK RD.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. K. KROELVITZ

400 N. HILTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3371 CERTIFICATE OF DEATH

03341

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY OR (If this place) <u>4 1/2 mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove Hospital</u>	STREET ADDRESS (If rural give location) <u>739 Dolphin St. ✓</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>CLARA V. ALLENBAUGH</u>		OF DEATH: <u>4</u> <u>9</u> <u>19 55</u>	
5. SEX: <u>+</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>About 1861 94 (?)</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Rep - Buyer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Joe's Hardware Dept.</u>	9. AGE last birthday: <u>94 (?)</u> yrs.
13. FATHER'S NAME: <u>Wm</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>?</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
16. SOCIAL SECURITY NO. <u>?</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Leedon</u>	
17. IMPORTANT ADDRESS: <u>Relative (?)</u>		18. MEDICAL CERTIFICATION	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
334X IMMEDIATE CAUSE	
ANTECEDENT CAUSE (S)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	
(A) <u>Similar with severe</u>	
(B) <u>Generalized atherosclerosis +</u>	
(C) <u>with cerebral deterioration</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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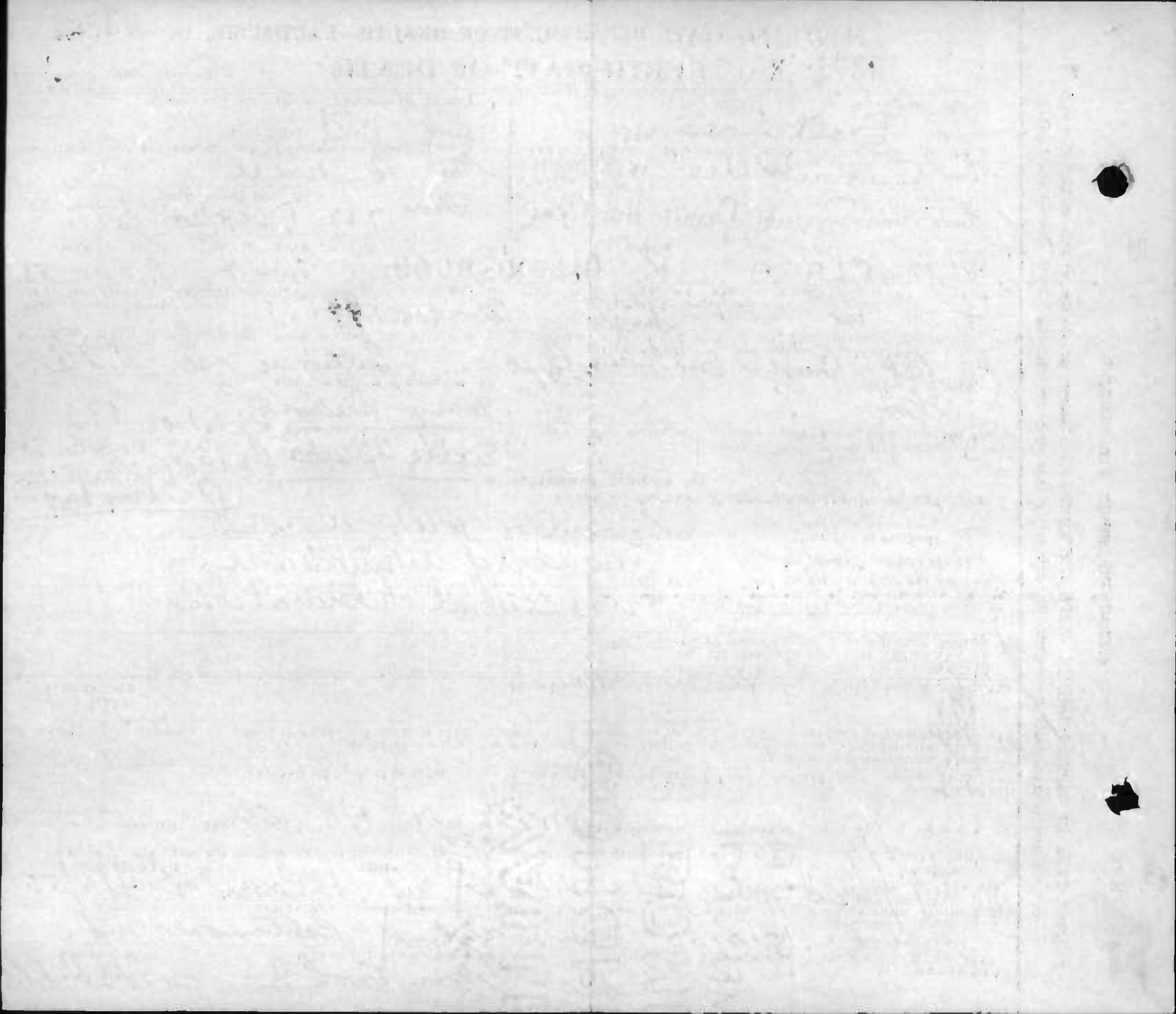
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/23, 1954 to 4/9, 1955, that I last saw the deceased alive on 4/9, 1955 and that death occurred at 3:30 P.M. from the causes and on the date stated above.

SIGNATURE <u>Spring Grove Hospital Catonsville, Md.</u>	DATE SIGNED <u>4/9/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>4/12/55</u>
NAME OF CEMETERY <u>New Cathedral</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>4-11-55</u>	REGISTRAR'S SIGNATURE <u>Dr. H. Cook, Jr.</u>
24. FUNERAL DIRECTOR ADDRESS <u>St. M. Cook & Co., 1217 B. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03342

3372

CERTIFICATE OF DEATH

Reg. Dist. No. 28 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) FORT HOWARD		LENGTH OF STAY (in this place) 5 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 227 SUDBROOK LANE (PIKESVILLE)			
3. NAME OF DECEASED: (First) FRANCIS (Middle) E. (Last) ANDREWS				4. DATE (Month) (Day) (Year) OF DEATH: APRIL 12 19 55			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED	8. DATE OF BIRTH: 1/15/88	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY: COURT		11. BIRTHPLACE (State or foreign country): TOWSON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: JOHN ANDREWS				14. MOTHER'S MAIDEN NAME: MARY MORAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) WW I				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT & ADDRESS: CLIN.REC., VET.ADM.HOSP., FORT HOWARD, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) THROMBOSIS OF MESENTERIC GLAND; HEMORR- HAGIC INFARCTION OF SMALL INTESTINE AND CECUM						8 DAYS	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from APR. 7, 1955 , to APR. 12, 1955 , that the deceased died on APR. 12, 1955 , and that death occurred at 5:35 PM , from the causes and on the date stated above.							
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.				ADDRESS M. D. VAN, FORT HOWARD, MARYLAND DATE SIGNED 4-13-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF APR 15, 1955		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR APR 13, 1955		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR HARVEY NEWELL FUNERAL HOME, REISTERSTOWN RD. PIKESVILLE, MARYLAND			

RECEIVED

APR 18 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03343
3373 CERTIFICATE OF DEATH Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>MT Carmel (Rural)</u> LENGTH OF STAY (in this place) <u>3-0-4-10</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>MT Carmel (Rural)</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>✓</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>EDDIE - C- ARMACOST.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 11</u> 19 <u>55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>July 8-1884</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Farming.</u>		11. BIRTHPLACE (State or foreign country): <u>Ind</u>	
13. FATHER'S NAME: <u>Joseph M Ammacost</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Schultz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-26-1484</u>		17. INFORMANT & ADDRESS: <u>Eletus Ammacost, Upper Md</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>MULTIPLE MYELOMA</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>54</u> to <u>April</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>55</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. M. France</u>		M. D. <u>Barkston Ind.</u>		DATE SIGNED <u>4/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr 13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Baptist</u>		LOCATION (City, town, or county) (State) <u>Balto Co Ind</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-12-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR <u>Edw E Tipton, Hampstead Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 18 1955

BUREAU V. S.

MARYLAND

3374

CERTIFICATE OF DEATH

03344
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Balt</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7712 Old Hartford</u>		STREET ADDRESS (If rural, give location) <u>7712 Old Hartford Rd</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>HELEN Marshall Ashley</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4 - 15 - 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>10-26-1916</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>38</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Truckton N. I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>yes</u>	
13. FATHER'S NAME <u>George B Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Martha M. Coffey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Howard W. Ashley 7712 Old Hartford</u>			

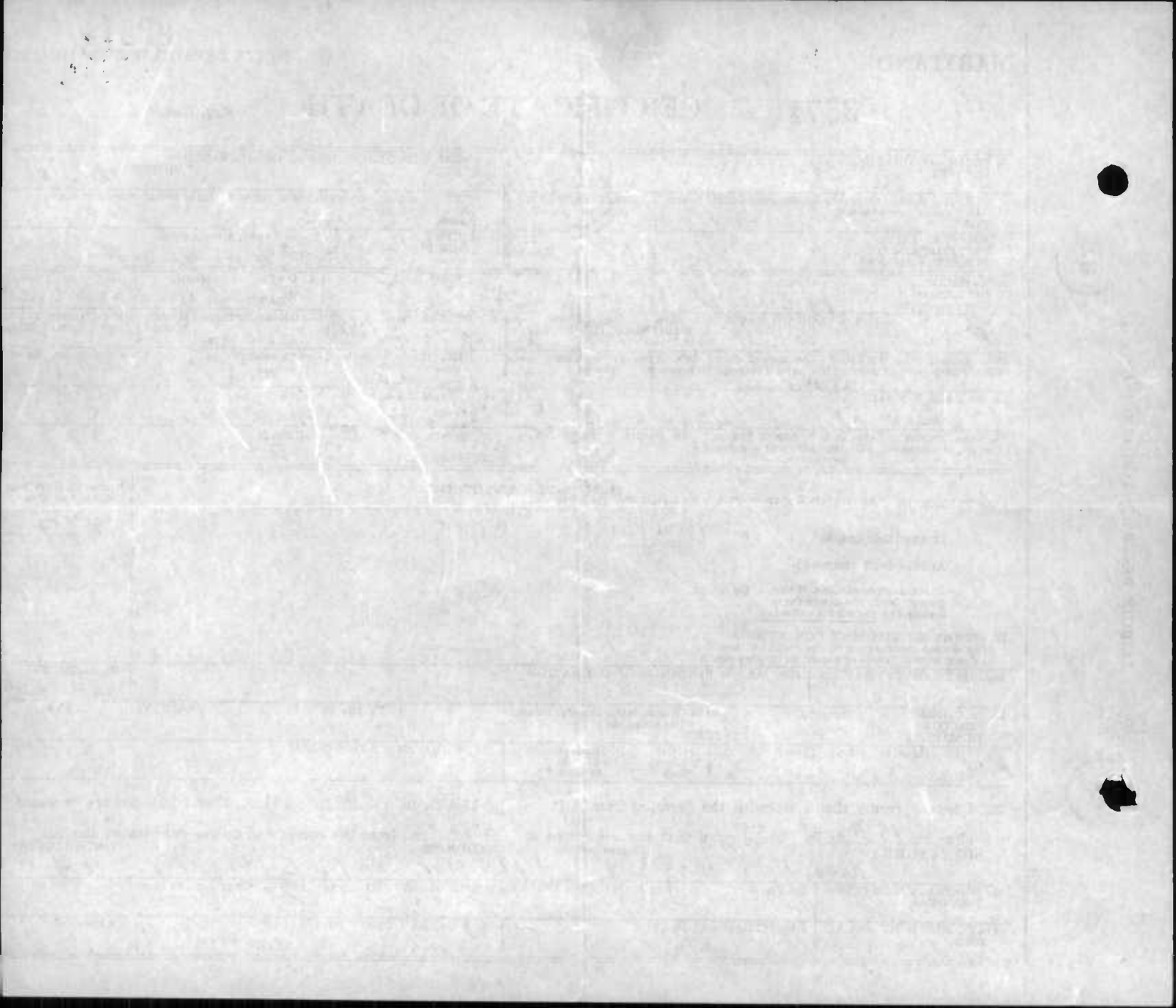
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
345X Immediate cause (a) <u>Multiple Sclerosis</u>		14 yrs.
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1954, to 15 April, 1955, that I last saw the deceased alive on 15 March, 1955, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE Edward L. Mufson (Degree or title) ADDRESS 7425 Hartford Rd Balto 14 Md DATE SIGNED 18 April 1955

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4-21-55</u>	NAME OF CEMETERY OR CREMATORY <u>Maryland Park</u>	LOCATION (City, town, or county) <u>Balt</u>
DATE REC'D BY LOCAL REG. <u>April 19/1955</u>	REGISTRAR'S SIGNATURE <u>H. W. Hedrich</u>	24. FUNERAL DIRECTOR <u>Edward J. Luck</u>	ADDRESS <u>5305 Hartford</u>

MARGIN RESERVED FOR BINDING



3375

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (if outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
X TOWN <u>Fort Howard</u>		1 Day		3V01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>710 N. Mount Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>WAYMAN</u> (NMI) <u>AUGUSTUS</u>				DEATH: <u>April 30, 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5/23/96</u>	9. AGE last birthday: <u>58</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chauffeur</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Wholesale Shoe Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
13. FATHER'S NAME: <u>Abraham Augustus</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
14. MOTHER'S MAIDEN NAME: <u>Susie Branson</u>				17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>212-01-4134</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>				UNKNOWN			
ANTECEDENT CAUSE (S) (B) <u>ARTERIOSCLEROSIS OF THE LEFT MIDDLE CEREBRAL ARTERY</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>							
<u>OLD RIGHT MIDDLE CEREBRAL ARTERY THROMBOSIS</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
		OF INJURY		INJURY OCCUR?		OF INJURY	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 29, 1955</u> , to <u>Apr. 30, 1955</u> , that I have seen the deceased alive on <u>XXXXXX 19XXXX</u> and that death occurred at <u>8:50</u> M. from the causes and on the date stated above.							
SIGNATURE <u>WINSTON C. DUDLEY</u>				DATE SIGNED <u>M. D. VAH, FORT HOWARD, MD.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-4-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-2-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Arlington S. Phillips Funeral Home</u>		ADDRESS <u>1808 N. Monroe Street, Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
BUREAU OF PUBLIC HEALTH

Form 101-1 (Rev. 1-65) (Instructions on back of form)

1. Name of person or organization reporting: _____
2. Address of person or organization reporting: _____
3. Date of report: _____

4. Name of patient: _____
5. Age: _____ Sex: _____ Race: _____

6. Date of birth: _____
7. Date of admission: _____

8. Name of physician: _____
9. Name of hospital: _____

10. Name of attending physician: _____
11. Name of attending nurse: _____

12. Name of attending pharmacist: _____
13. Name of attending dietitian: _____

14. Name of attending social worker: _____
15. Name of attending psychologist: _____

16. Name of attending psychiatrist: _____
17. Name of attending audiologist: _____

18. Name of attending speech therapist: _____
19. Name of attending occupational therapist: _____

20. Name of attending physical therapist: _____
21. Name of attending respiratory therapist: _____

22. Name of attending laboratory technician: _____
23. Name of attending radiologist: _____

MARYLAND STATE DEPARTMENT OF HEALTH

03346

3376

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH- COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Loug GREEN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Loug GREEN</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>07</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Lydia</u> <u>Ann</u> <u>BAKER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>4</u> <u>1955</u>	
6. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>April 18, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>67</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jackson Flowers</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Fasten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>Winfield Baker, Glenn Arm # R.D.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
Immediate cause

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Coronary Infarction (3rd) Interval BETWEEN ONSET AND DEATH 5 min.
(b) Arteriosclerotic Heart Disease 3 yrs.
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not While at <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/21, 1953, to April 4, 1955, that I last saw the deceased alive on 4/3, 1955, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

SIGNATURE Libford F. Hudson M.D. (Degree or title) ADDRESS Fork, Md. DATE SIGNED 4/4/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 7, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>	LOCATION (City, town, or county) (State) <u>Fountain Green, Harford, Md.</u>
DATE REC'D BY LOCAL REG. <u>4/11/55</u>	REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>	24. FUNERAL DIRECTOR <u>Joseph T. Foster, Bel Air, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3377

2411 N. Charles Street, Baltimore

03347

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Hampstead Rural</u> LENGTH OF STAY (In this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hampstead Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Albany Ave</u>		STREET ADDRESS (If rural, give location) <u>Albany Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Harry</u> (First) <u>Mosley</u> (Middle) <u>Baibitz</u> (Last)		4. DATE OF DEATH <u>April</u> (Month) <u>16</u> (Day) <u>1955</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 24, 1892</u>
9. AGE last birthday <u>62</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>August Baibitz</u>		14. MOTHER'S MAIDEN NAME <u>Florence E. Albau</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Florence E. Baibitz, Hampstead Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

(b)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>—</u>	PLACE (Home, farm, factory, street, OF office bldg, etc.) <u>—</u>	(CITY OR TOWN) <u>—</u>	(COUNTY) <u>—</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>		

22. I hereby certify that I attended the deceased from July 1, 1949, to April 16, 1955, that I last saw the deceasedalive on April 16, 1955, and that death occurred at 6:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/19/55</u>	NAME OF CEMETERY OR CREMATORY <u>Grave Hill</u>	LOCATION (City, town, or county) <u>Balto Co. Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>4-19-55</u>	REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>	24. FUNERAL DIRECTOR <u>Edw. C. Sipton</u>	ADDRESS <u>Hampstead Rd</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 21 1955

BUREAU V. S.

3378

CERTIFICATE OF DEATH

Reg. Dist. No

03348

PLEASE TYPE, OR WRITE PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. ly. The

Every item of information should be supplied. Physicians: please write the causes of death clearly and le, THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1. NAME OF DECEASED (Type or Print)		CARRIE MARIE M. BENNER		2. DATE OF DEATH April 12, 1955	
3. PLACE OF DEATH: A. Baltimore City, Maryland		Woodlawn, Balt. Co.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2607 Larchmont Drive		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Woodlawn		D. STREET ADDRESS (If rural, give location) 2607 Larchmont Drive	
c. Length of stay in Baltimore 00 Yrs. Mos. Days		5. SEX female		6. COLOR OR RACE white	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Aug. 6, 1893		9. AGE (in years, last birthday) 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George F. Mahle		14. MOTHER'S MAIDEN NAME Minnie Clifford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Paul A. Benner-2607 Larchmont Drive	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 416x ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					15 yr.
OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1949</u> to <u>April 1955</u> , that (I) (we) last saw the deceased alive on <u>April 1955</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.					
23A. SIGNATURE D. J. Schwartz		23B. ADDRESS 2320 Eutaw Place		23C. DATE SIGNED April 12, 1955	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/55		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md.		24E. FUNERAL DIRECTOR Wm. J. Vickrey & Sons		24F. ADDRESS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03349
3379 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Fort Howard</u>		<u>16 days</u>		OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>206 E. Melrose Avenue</u>			
3. NAME OF DECEASED: (First) <u>JOHN</u> (Middle) <u>C.</u> (Last) <u>BENZINGER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 17 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9/2/94</u>	9. AGE last birthday: <u>60</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Watchman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Gas & Electric Co. Baltimore</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frank Benzinger</u>				14. MOTHER'S MAIDEN NAME: <u>Mattie Carson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service): <u>WW-I</u>				16. SOCIAL SECURITY NO.: <u>213-07-5111</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u>							
ANTECEDENT CAUSE (S): <u>(A) CORONARY THROMBOSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>	
						DUE TO	
						DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
<u>VA</u>							
22. I hereby certify that I attended the deceased from <u>Apr. 1, 1955</u> , to <u>Apr. 17, 1955</u> , the <u>cause of death</u> was <u>coronary thrombosis</u> and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>				ADDRESS		DATE SIGNED <u>4-18-55</u>	
FRANCIS G. DICKEY, Chief, Medical Services M. D. VAH, Fort Howard, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>APRIL 21, 1955</u>		<u>Balto. National Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
				<u>Wm. Cook-Bright Inc., Funeral Home</u>		<u>Baltimore 14, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COMMITTEE ON THE STATE OF THE STATE

REPORT OF THE COMMITTEE ON THE STATE OF THE STATE

FOR THE YEAR 1900

ALBANY, N. Y., 1901

PRINTED BY THE STATE OF THE STATE

ALBANY, N. Y., 1901

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ALBANY, N. Y., 1901

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

3380

03350

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Providence</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Providence</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 14 Providence Road</u>		STREET ADDRESS (If rural, give location) <u>Box 14 Providence Road.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elbridge</u> (Middle) <u>F.</u> (Last) <u>Biggs</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>12-24-1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Test Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.&P. Tel. Co.</u>	9. AGE last birthday <u>73</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Milton E. Biggs</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Copeland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>212-05-0807</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Alice B. Mallonee</u>		<u>Box 14 Providence Rd.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause (a) <u>Coronary Arteriosclerosis</u>		<u>3-6 hours</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>		<u>?</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1954, to April, 1955, that I last saw the deceased alive on April 5, 1955, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE Spencer D. Gossberg M.D. ADDRESS McDaniel Ave. Belly DATE SIGNED 4/26/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>4-28-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Frederick Maus. Cloister</u>	LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>
DATE REC'D BY LOCAL REG. <u>4-26-55</u>	REGISTRAR'S SIGNATURE <u>Dr. Hadrich</u>	24. FUNERAL DIRECTOR <u>M.R. Etchison & Son</u>	ADDRESS <u>Frederick, Md.</u>

OUR

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Sylvan D. Goldberg
420 Med. Arts.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803351

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTO.		MARYLAND		STATE MD.		COUNTY HARTFORD	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 CATONSVILLE		LENGTH OF STAY (in this place) 23 months		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Aberdeen 1231.2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital				STREET ADDRESS (If rural give location) ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
CLYDE A. BLEVIN S				4-23-1955			
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S	8. DATE OF BIRTH: 1901	9. AGE last birthday 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: TROY BLEVENS				14. MOTHER'S MAIDEN NAME: CYNTHIA CANDILL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No If Yes, give war or dates of service		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS: 320 S. Phila. Bertha Day BLVD. Aberdeen, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 490X				(A) Left lobar pneumonia		3 days	
ANTECEDENT CAUSE (S):				(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypothyroidism							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-19-1953 to 4-23-1955 , that I last saw the deceased alive on 4-23-1955 and that death occurred at 2:45 PM , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED 4-24-55			
Harold E. Edwards M.D.		Spring Grove State Hospital					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 26, 1955		NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		LOCATION (City, town, or county) (State) Bel Air, Md.	
DATE REC'D BY LOCAL REGISTRAR 4/27/55		REGISTRAR'S SIGNATURE Victor S. Harry		24. FUNERAL DIRECTOR Joseph Turner Foster		ADDRESS West Broadway, Bel Air, Md.	

BUREAU V. S.

APR 28 1955

RECEIVED

3352

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

COUNTY BALTO. MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) DUNDALK 22 LENGTH OF STAY (in this place) 5 yrs
 TOWN DUNDALK 22
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 7308 FAIT AVE

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY BALTO.
 CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22
 TOWN DUNDALK 22
 STREET ADDRESS (If rural, give location) 7308 FAIT AVE

3. NAME OF DECEASED:

(First) WILLIAM(Middle) E(Last) BOWERS, SR.4. DATE OF DEATH: (Month) 4 (Day) 6 (Year) 1955

5. SEX:

MALE

6. COLOR OR RACE:

WHITE7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH:

3-7-1904

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

51 yrs.Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

FOREMAN

10b. KIND OF BUSINESS OR INDUSTRY:

SHIP BUILDING

11. BIRTHPLACE (State or foreign country):

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME:

GEORGE BOWERS

14. MOTHER'S MAIDEN NAME:

ELIZABETH WINEBURG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY No.:

216-10-8813

17. INFORMANT & ADDRESS:

AMELIA H. BOWERSSAME ADDRESS

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

CORONARY OCCLUSION

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

HYPERTENSION - ARTERIO-SCLEROSIS

DUE TO

(c)

Interval Between Onset And Death

24 Hours1 year?

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

✓

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7:24 1954, to Am 6 1955, that I last saw the deceasedalive on Am. 6 1955, and that death occurred at 5:00 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Morris A. Jacob MD1610 NORTH POINT RD. 4/6/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 6-1955William M. KellyNorth Point Road, Dundalk, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 7 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03353

3382

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>CHARLES</u>	(Middle) <u>HENRY</u>	(Last) <u>BRADY</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>1-26-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Newspaperman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>83</u> yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>DARTSVILLE W. VA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>PETER BRADY</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE MILLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT AND ADDRESS <u>WM BRADY, WOODLAWN MD</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>151X Carcinoma of stomach</u>			<u>3 months</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Cardio Vascular Disease</u>			<u>13 years.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION <u>no operation</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Dec 11, 1942, to April 20, 1955, that I last saw the deceased alive on April 15, 1955, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE Joshua H. Arno (Degree or title) M.D. ADDRESS 6419 Windsor Hill Rd Baltimore - 7 Md DATE SIGNED 4-20-55

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>4-22-55</u>	<u>NEW BETHEL</u>	<u>MARTINSBURG</u>	<u>W. VA</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-20-55</u>	<u>Aug. C. Russell</u>	<u>F. HIGGINBOTHAM</u>	<u>ELKOT CITY Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. A.

APR 22 1955

RECEIVED

CERTIFICATE OF DEATH

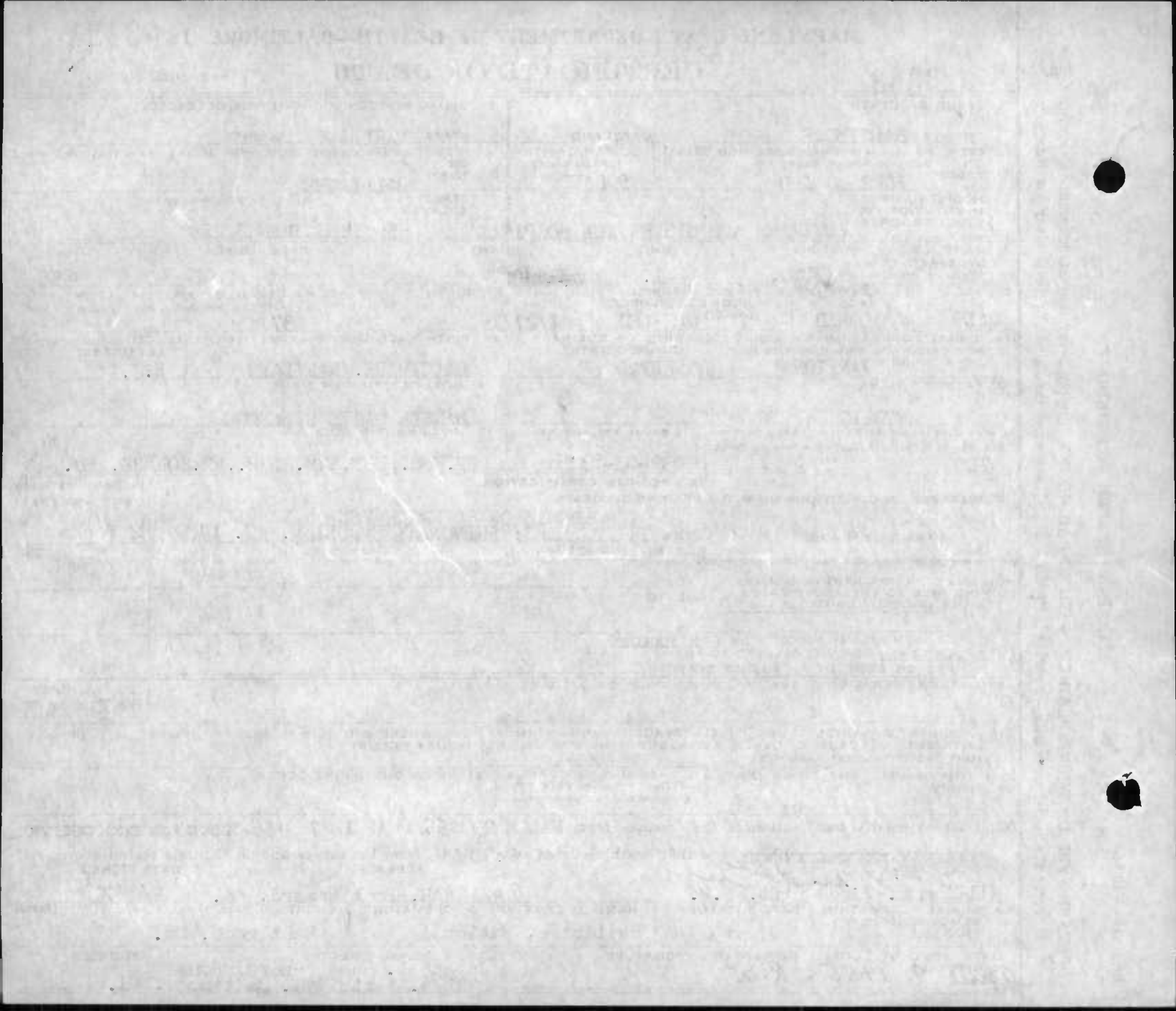
Reg. Dist. No. 44

3383

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) <u>FORT HOWARD</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STATE <u>MARYLAND</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>555 PRESSTMAN STREET</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>BRITTO, I. JOHN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 7 1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>7/27/15</u>
9. AGE last birthday <u>39</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>JANITOR</u>		12. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME: <u>ANTONIO BRITTO</u>		14. MOTHER'S MAIDEN NAME: <u>NANNIE MARIE BILLEPS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>039-03-8315</u>	
17. CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>465X</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) <u>THROMBOSIS OF SUPERIOR VENA CAVA AND TRIBUTARIES; PULMONARY EMBOLISM, RT. LUNG</u> DUE TO <u>UNKNOWN</u> (B) <u>UNKNOWN</u> DUE TO (C)		2 Weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MARCH 29 1955</u> , to <u>APRIL 7, 1955</u> , that I observed the deceased alive up to <u>9:30 A.M.</u> and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>William B. Vandegrift, M.D.</u> ADDRESS <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>4/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/11/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore, National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 9, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR <u>Joseph L. Russ Funeral Home</u>		ADDRESS <u>2222 W. North Ave. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

3384

CERTIFICATE OF DEATH

03355

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town X Mt. Washington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
6071 Falls Road.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Balto
 City or town Mt. Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6071 Falls Road.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Rose Ella Brookhart.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Benjamin Brookhart
Deceased 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) June 15, 1870
 8. AGE: Years 84 Months 3 Days 1 If less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Nathaniel Gover
 13. Birthplace Md
 14. Maiden name Martha ?
 15. Birthplace Md.

16. Informant Miss Anna E. Wilson.
 Address 6071 Falls Road.

17. Burial Date thereof April 25/55
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Pine Grove
 Location Balto Co. Md

18. Funeral director Austin E. Donovan
 Address 3818 Roland Ave

19. April 23 55 19 55
 (Date rec'd by registrar) Registrar R.W.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 19 55, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Apr 18 19 55 to Apr 22 19 55
 and that I last saw her alive on Apr 20 19 55

Immediate cause of death Coronary Heart Failure DURATION 4 days

Due to arteriosclerosis
C.V. Dis.

Due to 422.1

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

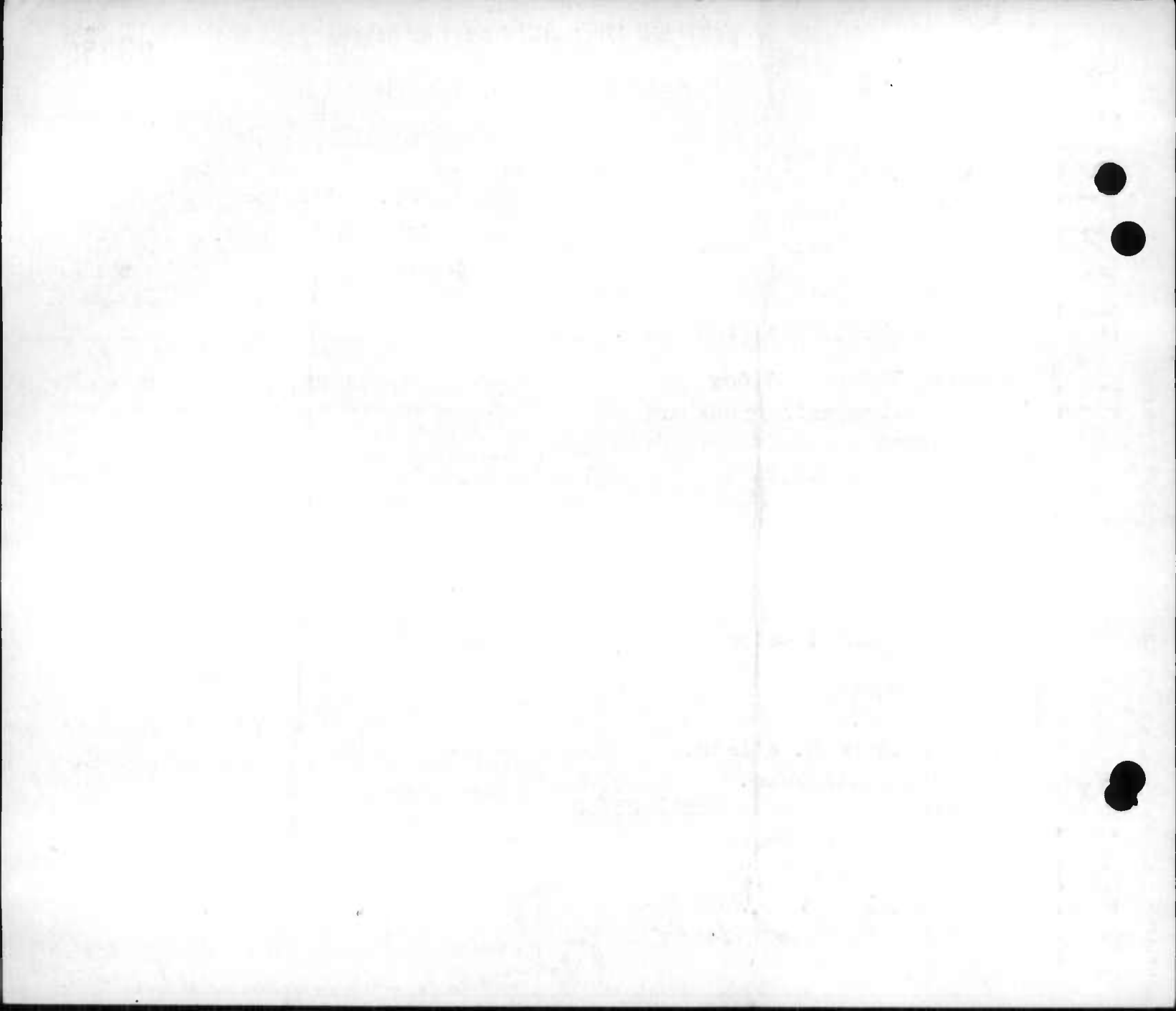
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. G. Glanville, M.D. M. D. or other

Address 4037 Falls Rd Date signed 4/23/55



CERTIFICATE OF DEATH

Reg. Dist. No.

3385		1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTO MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL BALTO ?		STATE MD COUNTY BALTO	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Woodbrook Lane		STREET ADDRESS (If rural give location) WOODBROOK LANE			
3. NAME OF DECEASED: (First) RIGGIN (Middle) BUCKLER (Last)		4. DATE OF DEATH: Apr 27 1955			
5. SEX: M 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED 8. DATE OF BIRTH: Nov 3 1882 72 yrs.		9. AGE last birthday: 72 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Architect 10b. KIND OF BUSINESS OR INDUSTRY: Own Firm		11. BIRTHPLACE (State or foreign country): Balto Md		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: RIGGIN BUCKLER		14. MOTHER'S MAIDEN NAME: ALICE W RIGGS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: -		17. INFORMANT & ADDRESS: Mrs RIGGIN Buckler SAME	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death	
420.0 Immediate cause (a) Anterovascular death disease DUE TO				9 yrs.	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Anterovascular - generalized DUE TO				15 yrs.	
(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 1, 1955, to Apr. 27, 1955, that I last saw the deceased alive on Apr. 22 1955, and that death occurred at 12:50 P.M. from the causes and on the date stated above.					
SIGNATURE C. Juveniles Bonds W.D.		ADDRESS 24 E. Eager St		DATE SIGNED 7/28/55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Oct 28 1955		NAME OF CEMETERY OR CREMATORY GREEN MOUNT	
DATE REC'D BY LOCAL REGISTRAR 7-28-55		REGISTRAR'S SIGNATURE		FURNERAL DIRECTOR	
				ADDRESS 4905 York Rd	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. C. Holmes Boyd
24 E. Eager
LE9-3061

9³⁰ A.M.

3386

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Parkton Rural</u>		<u>36 yrs</u>		TOWN <u>Parkton Rural</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>Erna</u>				<u>Erna</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print)		<u>Lula Bell Bull</u>		DEATH: <u>April 27</u>		<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>June 15, 1889</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas Thompson</u>				<u>Georgie Pearce</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>—</u>		<u>Mrs. Louis Layesman, Parkton Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
154X Immediate cause (a) <u>Generalized Carcinomatosis</u> DUE TO							
Antecedent cause(s) (b) <u>Primary Carcinoma of Rectum.</u> DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
<u>March 31, 1949</u>				<u>Primary Carcinoma Rectum</u>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
<u>—</u>		<u>—</u>		<u>—</u>		<u>—</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
<u>—</u>		<u>M.</u>		<u>—</u>			
22. I hereby certify that I attended the deceased from <u>March 1, 1949</u> , to <u>April 27, 1955</u> , that I last saw the deceased alive on <u>April 27, 1955</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE				(DEGREE OR TITLE)		ADDRESS	
<u>Joseph E. Bull</u>				<u>M.D.</u>		<u>Hampstead Md</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 30, 1955</u>		<u>Mt. Carmel</u>		<u>Parkton, Md.</u>	
DATE REC'D BY LOCAL		RECEIVED BY SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Apr 27 1955</u>		<u>Charles J. Reardon</u>		<u>J. Paul Henderson</u>		<u>New Freedom</u>	

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 2 1955

RECEIVED

3387

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTO. CO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1300 Summit Ave</u>		STREET ADDRESS (If rural, give location) <u>1300 Summit Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>C. Clarence Stephen Cahill</u>	4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>9</u> (Year) <u>1955</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 11, 1888</u>
9. AGE last birthday <u>67</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Manager</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Michael Cahill</u>	14. MOTHER'S MAIDEN NAME <u>Margaret Ryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>182-09-7762</u>	17. INFORMANT <u>Mary C. Cahill</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>	<u>20 min.</u>
Antecedent cause(s) (b) <u>Acute & chronic alcoholism</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.	<u>Acute & chronic alcoholism</u>	10 months
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>None</u>	(CITY OR TOWN) <u>None</u> (COUNTY) <u>None</u> (STATE) <u>None</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at work <u>None</u> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>None</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) D. D. Caples M.D. ADDRESS 6 Hanover Rd. Reisterstown, Md. DATE SIGNED 4/11/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/12/55</u>	NAME OF CEMETERY OR CREMATORY <u>N. CEDAR HILL</u>	LOCATION (City, town, or county) <u>PHILA. PA.</u>	(State) <u>PA.</u>
DATE REC'D BY LOCAL REG. <u>4/11/55</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	24. FUNERAL DIRECTOR <u>Mac Nabb & Son</u>	ADDRESS <u>Catonville Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 13 1955

BUREAU V. 31

CERTIFICATE OF DEATH

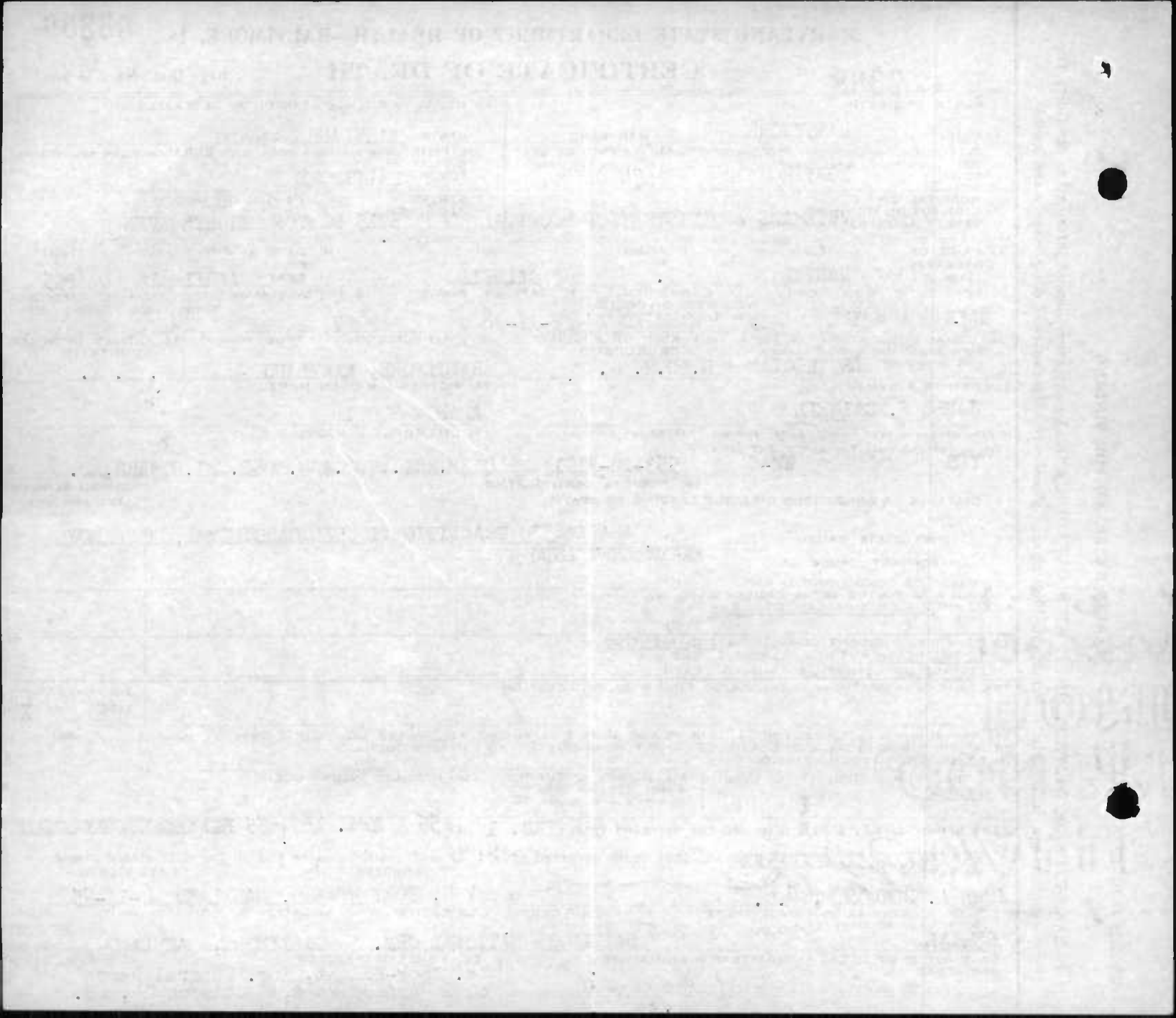
Reg. Dist. No. 44

3388

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) FORT HOWARD		LENGTH OF STAY (in this place) 74 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 5915 BENTON HEIGHTS AVENUE					
3. NAME OF DECEASED: (First) (Middle) (Last) DANIEL S. CALWELL				4. DATE (Month) (Day) (Year) OF DEATH: APRIL 16 1955			
5. SEX: MALE		6. COLOR OR RACE: WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH: 2-12-98	
9. AGE last birthday: 57 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIAN				10B. KIND OF BUSINESS OR INDUSTRY: B.&O.R. R.			
13. FATHER'S NAME: JAMES S. CALWELL				14. MOTHER'S MAIDEN NAME: AMANDA SCOTT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) WW-I				16. SOCIAL SECURITY NO. 553-10-2191		17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 163X ANAPLASTIC TRANSITIONAL CELL CARCINOMA,						UNKNOWN	
ANTECEDENT CAUSE (S): ENLARGED LEFT LUNG							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from FEB. 1, 1955 , to APR. 16, 1955 , and that death occurred at 4:50 A.M. from the causes and on the date stated above.							
SIGNATURE JOHN A. SURMONTE, M.D.		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND		DATE SIGNED 4-16-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF APRIL 19, 1955		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 4-19-55		REGISTRAR'S SIGNATURE A. W. HARRIS		24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Blight, Inc. Funeral Home 6009 Harford Road, Baltimore 14, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 45

3389

1. PLACE OF DEATH:

COUNTY BALTO MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN HAREWOOD PK LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS
ROUTE 14 BOX 408

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY BALTO
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN HAREWOOD PK
 STREET ADDRESS (If rural give location)
ROUTE 14 BOX 408

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

GeorgeWashingtonCarback

4. DATE OF DEATH:

(Month)

(Day)

(Year)

(Type or Print)

April 201955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

MWWIDOWEDAUG. 12-18748080 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1
Immediate cause(a) Cerebral apoplexy.
DUE TOAntecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.(b) Arteriosclerosis Cardiovascular disease
DUE TO

(c)

Interval Between Onset And Death

Sudden2 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Carcinoma of Stomach

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

May 1954Partial Gastrectomy

20. AUTOPSY ?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from March 1, 1955, to April 20, 1955, that I last saw the deceasedalive on April 20, 1955, and that death occurred at 3:16 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

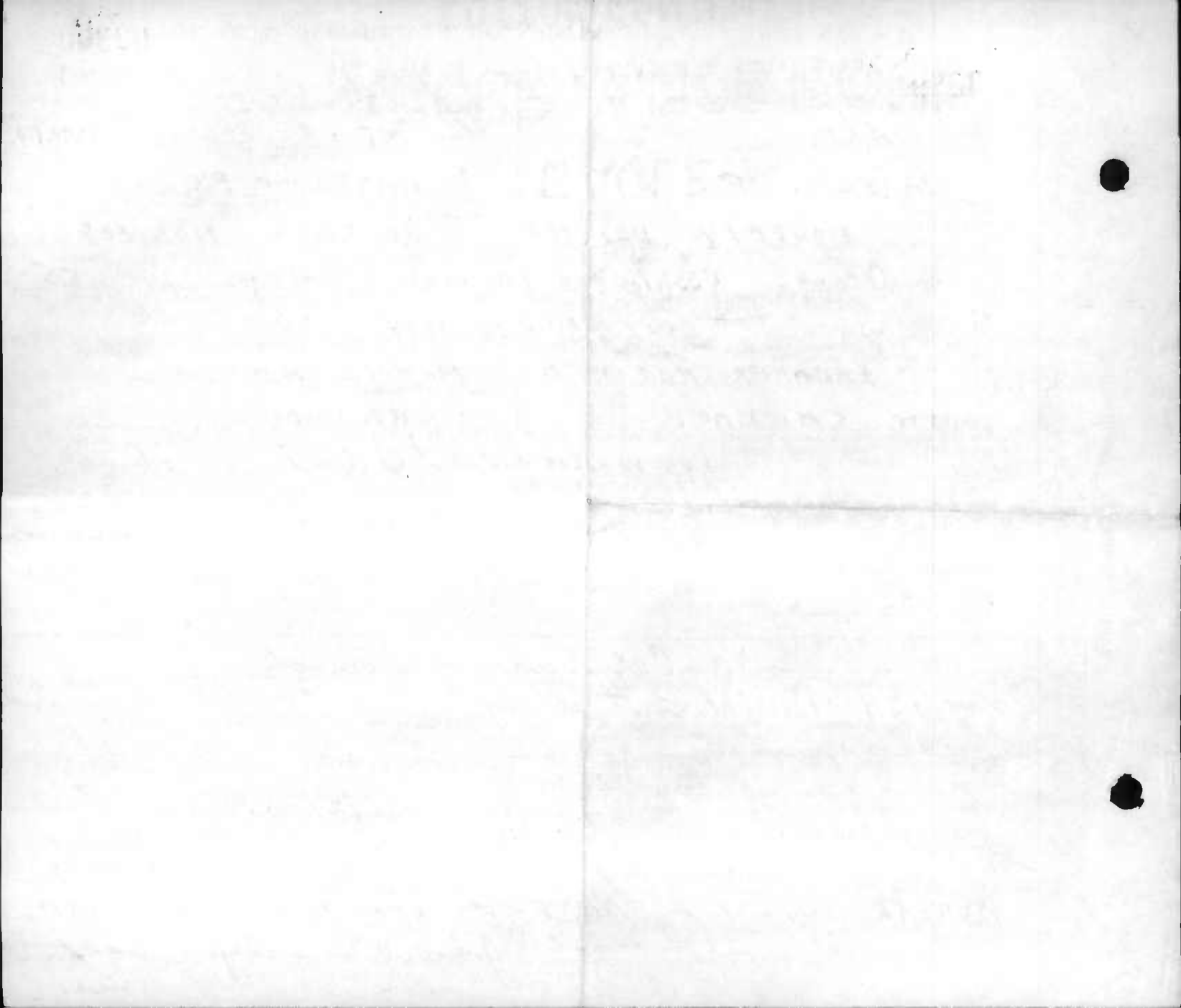
24. FUNERAL DIRECTOR

ADDRESS

4-22-55Am. Red CrossJohn D. ConnellyEastmd.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



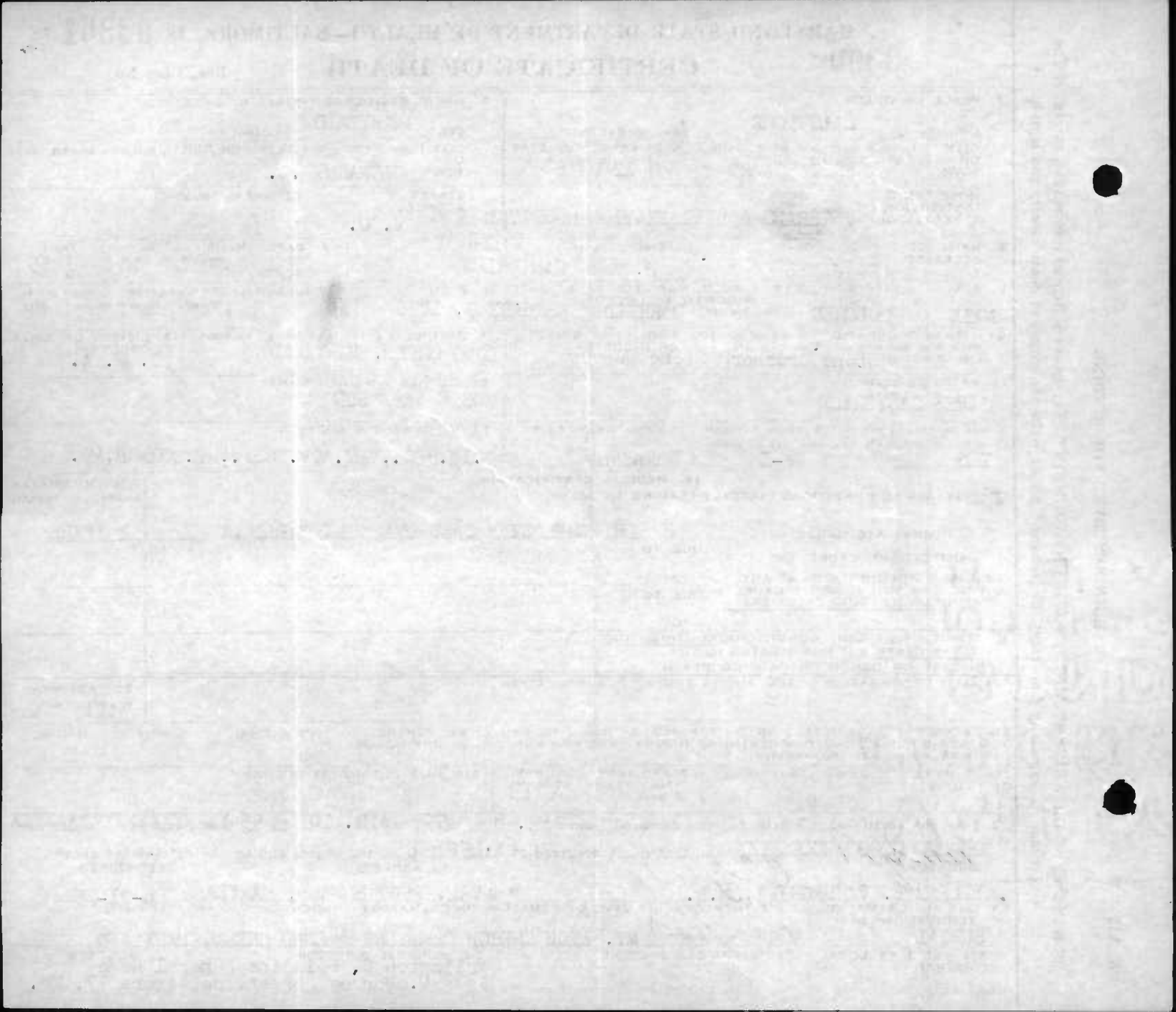
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **03361**
3390
CERTIFICATE OF DEATH

Reg. Dist. No. **44**...

1. PLACE OF DEATH: COUNTY BALTIMORE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD TOWN 12 DAYS HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) GLENARM TOWN P. O. STREET ADDRESS (If rural give location)															
3. NAME OF DECEASED: (First) (Middle) (Last) JAMES H. CASTERLOW (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH: APRIL 20 19 55															
5. SEX: MALE		6. COLOR OR RACE: COLORED		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED		8. DATE OF BIRTH: FEBRUARY 3, 1896		9. A. E last birthday 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone Crusher				10B. KIND OF BUSINESS OR INDUSTRY: Stone Quarry				11. BIRTHPLACE (State or foreign country): LONG GREEN, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME: JAMES CASTERLOW								14. MOTHER'S MAIDEN NAME: ROSIE ANDERSON											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): YES (If Yes, give war or dates of service) WW-I				16. SOCIAL SECURITY NO.: Unknown				17. INFORMANT & ADDRESS: CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.											
18. MEDICAL CERTIFICATION												INTERVAL BETWEEN ONSET AND DEATH							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) HYPERTENSIVE CARDIOVASCULAR DISEASE ANTECEDENT CAUSE (S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)												2 YEARS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.																			
19A. DATE OF OPERATION:								19B. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY				21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.								21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from APR. 8, 1955, to APR. 20, 1955, that I last saw the deceased on APR. 20, 1955, and that death occurred at 1:45 PM, from the causes and on the date stated above. SIGNATURE WILLIAM B. VANDEGRIFT, M.D. M. D. VAH, FORT HOWARD, MARYLAND 4-21-55																			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				DATE THEREOF 4/22/55				NAME OF CEMETERY OR CREMATORY MT. ZION CHURCH CEMETERY				LOCATION (City, town, or county) (State) LONG GREEN, MARYLAND							
DATE REC'D BY LOCAL REGISTRAR 4-22-55				REGISTRAR'S SIGNATURE A W. [Signature]								24. FUNERAL DIRECTOR Arlington S. Phillips Funeral Home 1808 N. Monroe Street, Baltimore 17, Md.							

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3391

03362

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 37

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>COCKEYSVILLE</u> LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>W. Pott Spring Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>TOWSON</u> 55 STREET ADDRESS (If rural, give location) <u>12 W. JOPPA ROAD</u> 1	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Benjamin Franklin Cavey Jr</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 5 1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE. MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>JUNE 7, 1915</u>
9. AGE last birthday: <u>39</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>PRINT SHOP</u>	
11. BIRTHPLACE (State or foreign country): <u>USA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>BENJAMIN F. CAVEY, SR.</u>		14. MOTHER'S MAIDEN NAME: <u>LULA PRUITT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY No.: <u>215-07-5289</u>	
17. INFORMANT & ADDRESS: <u>SERVICE RECORD</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 973.1 Immediate cause (a) <u>Carbon monoxide poisoning (in auto)</u> DUE TO Antecedent cause(s) (b) <u>Carbon monoxide poisoning (in auto)</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Rollinb. Hudson D.M.E.</u>		M. D. <u>4/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>APRIL 8, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEM.</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
DATE REC'D BY LOCAL REG. <u>12 April 1955</u>		24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>	

RECEIVED
APR 14 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03363
3392 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN FORT HOWARD		40 Days		TOWN SNOW HILL			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) R.F.D. #2			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
WOODY CHATHAM				APRIL 23, 19 55			
5. SEX: MALE		6. COLOR OR RACE: WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE		8. DATE OF BIRTH: 5-2-91	
9. AGE last birthday 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Farm	
11. BIRTHPLACE (State or foreign country): Worcester Co., Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: ELIJAH CHATHAM				14. MOTHER'S MAIDEN NAME: ARLENE STEWART			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes (If Yes, give war or dates of service) WW-1				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) CEREBROVASCULAR ACCIDENT						24 HOURS	
ANTECEDENT CAUSE (B) DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						10 YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. BRONCHIAL ASTHMA; PULMONARY EMPHYSEMA							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 14, 19 55 to April 23, 19 55 and that death occurred at 2:10 PM , from the causes and on the date stated above.							
SIGNATURE JOSEPH SHEAR				DATE SIGNED 4-23-55			
M. D. VAH, FORT HOWARD, MARYLAND							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4-26-55		NAME OF CEMETERY OR CREMATORY OLIVET CEMETERY		LOCATION (City, town, or county) (State) WORCESTER CO., MARYLAND	
DATE RECD BY LOCAL REGISTRAR April 27-55		REGISTRAR'S SIGNATURE George L. Harbor		24. FUNERAL DIRECTOR GEORGE L. SCHWAB		ADDRESS 2101 Frederick Ave., Baltimore, Maryland	

BUREAU V. S.

APR 29 1955

RECEIVED

3392

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03364

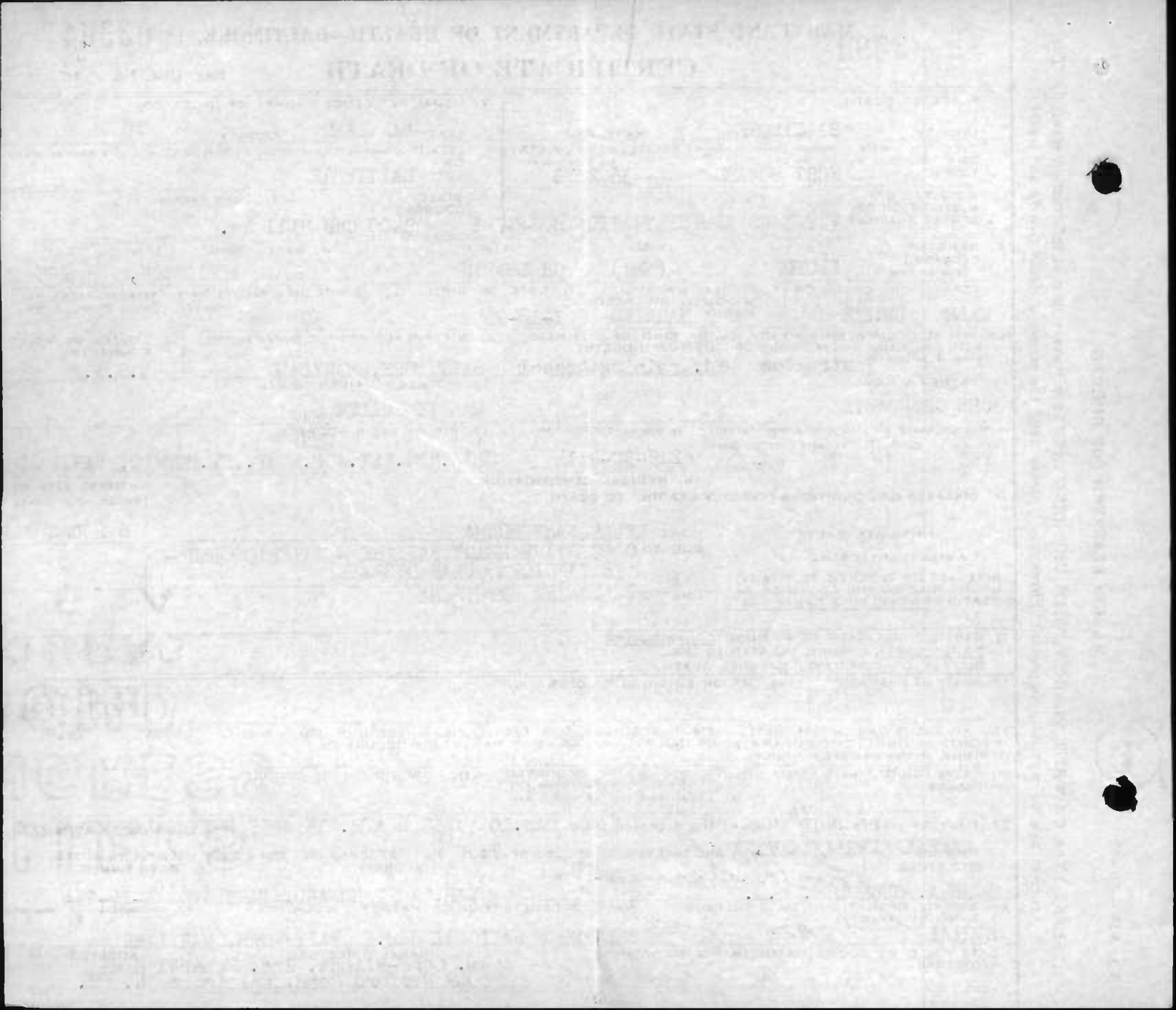
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		LENGTH OF STAY (in this place) 36 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 2400 Cub Hill Rd.			
3. NAME OF DECEASED: (First) (Middle) (Last) LYOYD (NMI) CHENOWETH				4. DATE (Month) (Day) (Year) OF DEATH: APRIL 15, 1955			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 1-18-96	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Instructor Md/Training School				10B. KIND OF BUSINESS Boys OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND	
13. FATHER'S NAME: JOHN CHENOWETH				14. MOTHER'S MAIDEN NAME: MANNIE FULLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): YES		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service): WW-I 215-30-4314		17. INFORMANT & ADDRESS: CLIN.REC.VET.ADM.HOSP., FT.HOWARD, MARYLAND			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						8 HOURS	
422.1 IMMEDIATE CAUSE (A) PULMONARY EDEMA							
ANTECEDENT CAUSE (S) DUE TO CONGESTIVE HEART FAILURE - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO PULMONARY EMPHYSEMA							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from MAR. 10, 1955 , to APR. 15, 1955 , and that death occurred at 7:40 M. from the causes and on the date stated above.							
SIGNATURE John A. Surmonte		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND		DATE SIGNED 4-16-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF APRIL 19, 1955		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 4-19-55		REGISTRAR'S SIGNATURE A W Hedrick		24. FUNERAL DIRECTOR Wm. Cook-Blight, Inc. Funeral Home		ADDRESS 6009 Harford Road, Baltimore 14, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3394
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03365
 Reg. Dist.

No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>6yr. 9mo. 2days</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Baltimore</u>		<u>3101.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural, give location) <u>Seton Institute 1019 E. Hoffman St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Joseph F. Coffay</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 1, 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>4-19-1888</u>	9. AGE last birthday: <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John F. Coffay</u>				14. MOTHER'S MAIDEN NAME: <u>Mary A. Tierney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Coronary thrombosis</u> DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Geo S McKieffer</u>		1010 Leeds Ave		M. D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-1-55</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>April 4-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		LOCATION (City, town, or county) (State) <u>4430 Belair Rd. Balto Md.</u>	
DATE REC'D BY LOCAL REG. <u>April 2. 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Joseph J. J. Inc. 712-74 E. North Ave</u>			

100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3395

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03366

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <u>Catonsville</u>		8mo. 20days		OR TOWN <u>Dundalk 22,</u> 53			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>8241 Bullneck Road</u> 1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
(Type or Print) <u>James C. Cook</u>				<u>April 29,</u> 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Widowed	2-16-1874	81 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Telephone Co.</u>				<u>Massachusetts</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Eugene Cook</u>				<u>Elizabeth Cook</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Unknown</u>				<u>Unknown</u>		<u>Records Spring Grove State Hosp.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						5 days	
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerotic cardiovalvular disease</u>						Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-9-54, to 4-29-1955, that I last saw the deceased alive on 4-29-1955, and that death occurred at 11:40 AM from the causes and on the date stated above.							
SIGNATURE <u>S. Wachser</u>				DATE SIGNED <u>4-29-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>				<u>Catonsville 28, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>APR 30, 1955</u>				24. FUNERAL DIRECTOR ADDRESS			
REGISTRAR'S SIGNATURE <u>V.E. Harris</u>				<u>Post Haven Funeral Chapel Inc. Hagerstown Md</u>			

BUREAU V. S.

MAY 5 1959

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

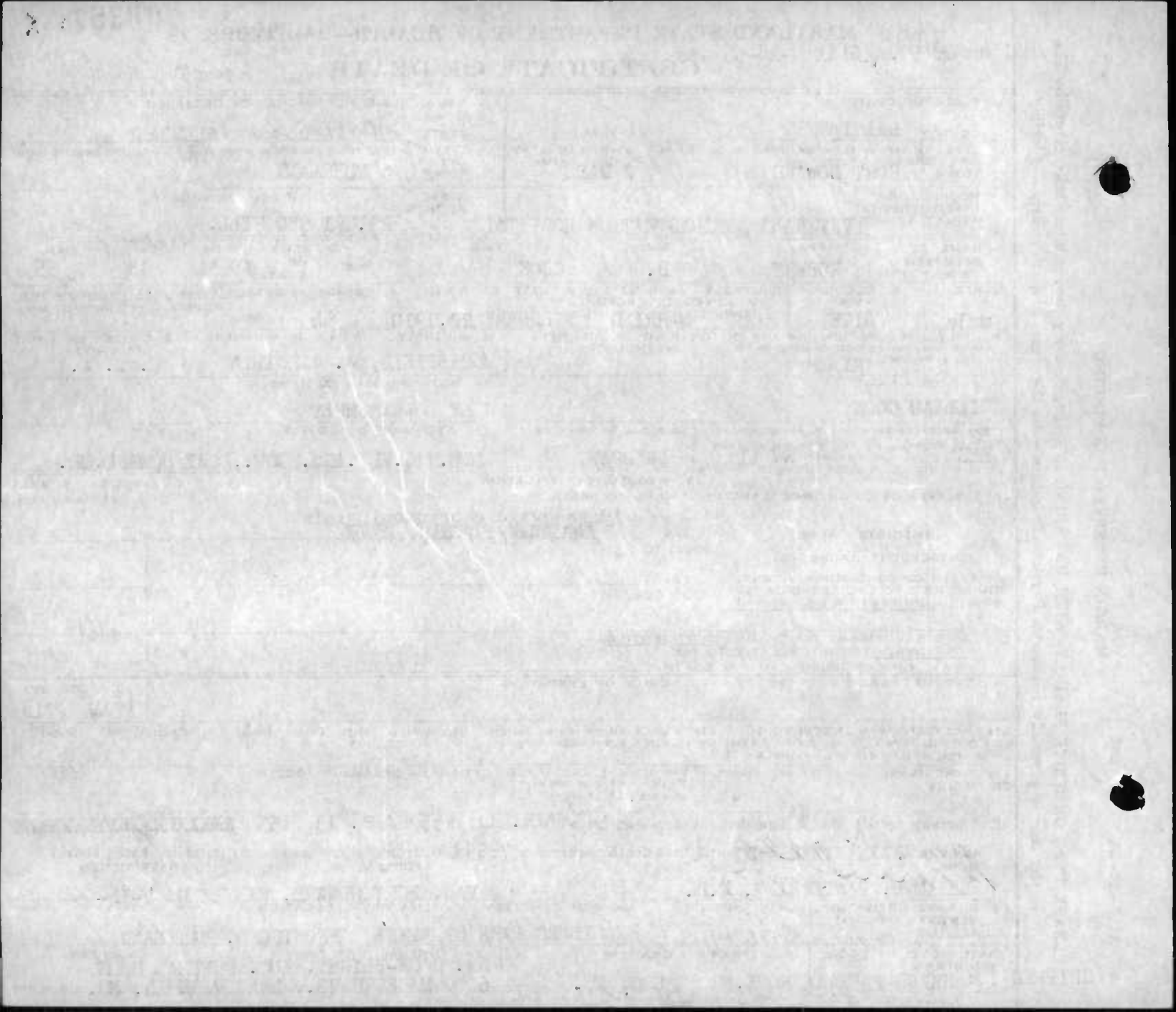
Item 3396 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03367
 18-11-11 6181 5-18-55 am

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL) OR TOWN FORT HOWARD	LENGTH OF STAY (in this place) 2 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) RT. #1 RED HILL,	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
ROBERT D. COOK		APRIL 13 19 55	
5. SEX: male	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: FEBRUARY 22, 1910
9. AGE last birthday 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINER		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): MOOREFIELD, W. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: WILLIAM COOK		14. MOTHER'S MAIDEN NAME: JANE LOWDERSHELT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): YES (If Yes, give year or dates of service) WW II		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FORT HOWARD, MD.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Lymphocytic choriomeningitis			
ANTECEDENT CAUSE (B) AWAITING FURTHER STUDY			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from APR. 11, 19 55 to APR. 13, 19 55 , and that death occurred at 7:55 A M. from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL REMOVAL		DATE THEREOF APRIL 14, 19 55	
NAME OF CEMETERY OR CREMATORY FROSTBURG PARK CEMETERY		LOCATION (City, town, or county) FROSTBURG, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR TO: HAFFER FUNERAL HOME, FROSTBURG, MD.		24. FUNERAL DIRECTOR ADDRESS WM. COOK-BLIGHT, INC. FUNERAL HOME 6009 HARFORD RD., BALTIMORE 14, MD.	

SHIPPED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

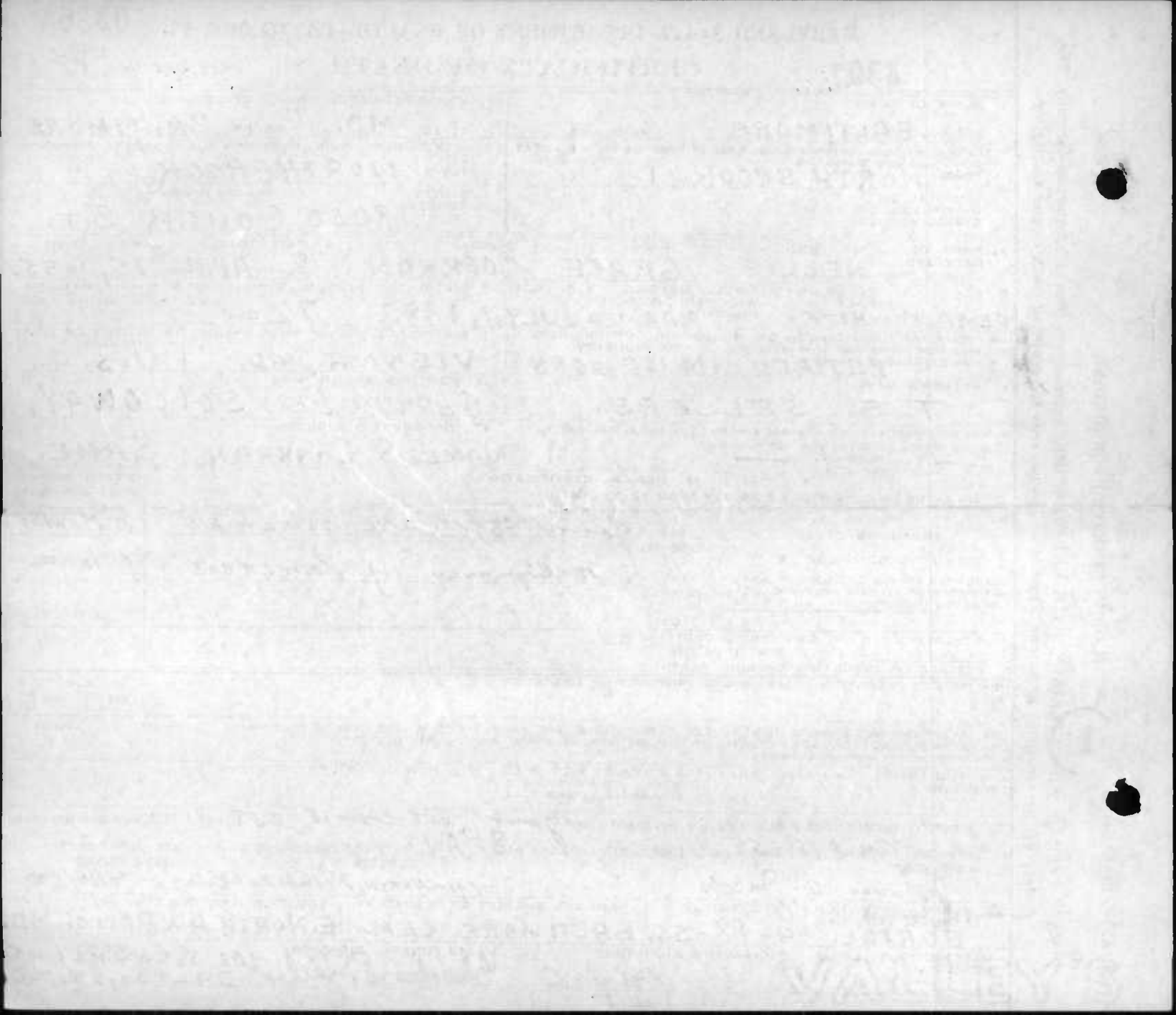
03368

3397

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MD.	COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
NORTH BROOK		NORTH BROOK	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		8050 GOUGH ST.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
NELLIE GRACE CORKRAN		DEATH: APRIL 15, 1955.	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
FEMALE	WHITE	MARRIED	JULY 1, 1882
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
72 yrs.		U.S.A.	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
VIENNA, MD.		U.S.A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
T. S. SELLERS.		GERTRUDE SOLLOWAY.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
JAMES S. CORKRAN SAME.		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		8 Months	
1997 IMMEDIATE CAUSE (A) Generalized Carcinomatosis		4 Months	
ANTECEDENT CAUSE (S) (B) Malignancy of Pancreas			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 2 19 55 , to Apr 15 , 19 55 that I last saw the deceased alive on April 15, 1955 , and that death occurred at 8:10 A M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Monie G. Jacobs		4/16/55	
M. D. 1010 NORTH Point Rd. Bldg 24			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
BURIAL		BALTIMORE CEM.	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
4-18-55		E. NORTH AV. BALTO., MD.	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
A. W. H. Smith		Charles S. Geiler	
		ADDRESS	
		901 S. CONKLINGS BALTO., MD.	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3398

CERTIFICATE OF DEATH

03369

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY Balto. MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 House in the Pines 16 Fusting Avenue		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Balto. CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 TOWN STREET ADDRESS (If rural give location) 35 N. Abington Ave. ✓	
3. NAME OF DECEASED: (First) (Middle) (Last) Type or Print: MAMIE E. CRABILL		4. DATE (Month) (Day) (Year) OF DEATH: Apr. 5, 1955	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: May 22, 1881
9. AGE last birthday 73 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: Thomas Toms	
14. MOTHER'S MAIDEN NAME: Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 212-03-8527 B		17. INFORMANT & ADDRESS: Mr. S. Durward Crabill - 35 N. Abington Av	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332X IMMEDIATE CAUSE (A) Pulmonary Edema ANTECEDENT CAUSE (B) Cerebral Embolism DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hemiplegia			INTERVAL BETWEEN ONSET AND DEATH 1 day 3 Mts 3 Mts
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan 4, 1955 , to Apr 5, 1955 , that I last saw the deceased alive on Apr 4, 1955 , and that death occurred at 6:10 P. M. from the causes and on the date stated above. SIGNATURE James L. Latzenberger M.D. 4123 Rockville Ave Baltimore DATE SIGNED 4/5/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/8/55	NAME OF CEMETERY OR CREMATORY Lorraine Cem.
LOCATION (City, town, or county) Woodlawn, Md.		24. FUNERAL DIRECTOR ADDRESS Wm. J. Pickens & Sons - Balt. 17	
DATE REC'D BY LOCAL REGISTRAR 4-7-55		REGISTRAR'S SIGNATURE A W. H. H. H.	

COMMUNICATIONS SECTION

RECEIVED

EX-115

3399

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Howard	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN Owings Mills		2 1/2 yrs.		TOWN Ellicott City		13 X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood Training School				STREET ADDRESS (If rural give location) 390 Main Street			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
David Anthony Cross				4 10 19 55			
5. SEX: male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single		8. DATE OF BIRTH: 11/1/49	
9. AGE last birthday: 5 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): ---				10b. KIND OF BUSINESS OR INDUSTRY: ---		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME: Vernon Daniel Cross				14. MOTHER'S MAIDEN NAME: Ramona Ridgley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) ---				16. SOCIAL SECURITY No.: ---			
17. INFORMANT & ADDRESS: Rosewood Records, Owings Mills, Maryland							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
921.7 Immediate cause (a) Subacute suffocation due to obstruction of Antecedent causes (s) (b) lower airways by aspirated food. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)						12 hours	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY		Beth. Co.		Beth. Co.	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
m.							
22. I hereby certify that I attended the deceased from 9/4/52 , 19....., to 4/10/55 , 19....., that I last saw the deceased alive on 4/10/55 19....., and that death occurred at 11:55 P.M. , from the causes and on the date stated above.							
SIGNATURE H. B. Butler M.D. (Degree or title)				ADDRESS Owings Mills, Md. DATE SIGNED 4/11/55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		4/12/55		Good Shepherd		Ellicott City, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
4-12-55		Mary B. Eline		Easton Bone Catonsville, Md.			

BUREAU V. S.

APR 18 1955

RECEIVED

3400

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03371

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Fort Howard</u>		<u>9 Hrs. 5 Min.</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 Veterans Administration Hospital</u>				<u>917 Wilmer Court</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH		5. SEX:		6. COLOR OR RACE:	
<u>MARTIN L DAVIS</u>		<u>April 5 1955</u>		<u>Male</u>		<u>Colored</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:		9. AGE last birthday		IF UNDER 1 YEAR	
<u>Widowed</u>		<u>11/15/92</u>		<u>62</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Steel Mill</u>		<u>Plainfield, Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Davis</u>				<u>Hannah Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes</u> <u>WW-I</u>				<u>212 01 8968</u>		<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>422.1</u>							
IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE (S) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, DECOMPENSATED.</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 4, 1955</u> to <u>April 5, 1955</u> , and that death occurred at <u>4:05 A M.</u> from the causes and on the date stated above.							
SIGNATURE <u>F. S. Dickey</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>4/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/8/1955</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-7-55</u>		<u>A. W. Redding</u>		<u>Arlington S. Phillips</u>		<u>1808 N. Monroe St. Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK

IN SENATE, JANUARY 1, 1900.

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

ALBANY: JAMES B. LEECH, STATE PRINTER, 1900.

THE COMMISSIONER OF THE LAND OFFICE.

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THE COMMISSIONER OF THE LAND OFFICE.

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THE COMMISSIONER OF THE LAND OFFICE.

ALBANY: JAMES B. LEECH, STATE PRINTER, 1900.

THE COMMISSIONER OF THE LAND OFFICE.

MARYLAND

03372
STATE DEPARTMENT OF HEALTH

3401

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>52</u> TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>52</u> <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>70</u> <u>12 PAYSON AVE.</u>		STREET ADDRESS (If rural, give location) <u>1</u> <u>12 PAYSON AVE.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM</u> <u>FRANKLIN</u> <u>DAVIS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4</u> - <u>9</u> <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>OCT. 13, 1880</u>
9. AGE last birthday <u>74</u> yrs.		10. If under 1 year 1 year 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILLER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOUGHNUT MILL</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ROBERT DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>ISABEL KEYS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Wm. Roger Davis - 165 Buckwood Ave.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> Antecedent cause(s) (b) <u>Hypertension</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>55</u> , to <u>4/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>55</u> , and that death occurred at <u>7:45 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Wm. Roger Davis</u>		DATE SIGNED <u>4-12-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE <u>4-12-55</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>4/12/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Julius T. Ford Home, Catonsville, Md.</u>		<u>1401 N. 4th St.</u>	

RECEIVED

APR 13 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03373

CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL OR and give nearest town) FORT HOWARD	LENGTH OF STAY (in this place) 40 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 7319 HOLABIRD AVE.	
3. NAME OF DECEASED: (First) CHARLES (Middle) S. (Last) DEAVER		4. DATE (Month) (Day) (Year) OF DEATH: APRIL 13 1955	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): WIDOWED	8. DATE OF BIRTH: 8-12-77
9. AGE last birthday 77 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asbestos Worker		10B. KIND OF BUSINESS OR INDUSTRY: PIPE COVERING	
11. BIRTHPLACE (State or foreign country): MORRISTOWN, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: JOHN DEAVER		14. MOTHER'S MAIDEN NAME: HESTER (MAIDEN NAME UNKNOWN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) YES SAW		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT & ADDRESS: CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) HYPERTENSIVE CARDIOVASCULAR DISEASE		UNKNOWN	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from MARCH 4, 1955 , to APRIL 13, 1955 , and that death occurred at 9.05A M., from the causes and on the date stated above.			
SIGNATURE William B. VanDeGrift, M.D.		DATE SIGNED APRIL 14-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF APRIL 15 1955	
NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		LOCATION (City, town, or county) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR APR 14-55		24. FUNERAL DIRECTOR WM. COOK-BLIGHT, INC. FUNERAL HOME	
REGISTRAR'S SIGNATURE [Signature]		ADDRESS 6009 HARFORD RD. BALTIMORE 11, MD	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3353

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 41

03374

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>DUNDALK</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Gray Manor</u>	53
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2610 Ambler Road</u>		STREET ADDRESS (If rural, give location) <u>2610 Ambler Road</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>LILLIAN</u>	(Middle)	(Last) <u>Dietrich</u>	(Month) <u>April</u> (Day) <u>8</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 22, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	9. AGE last birthday: <u>65</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Peter Fooks</u>		14. MOTHER'S MAIDEN NAME: <u>Katherine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: <u>George L. Dietrich 2610 Ambler Road</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
420.1 Immediate cause (a) <u>Coronary Occlusion</u> DUE TO			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>W. B. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/8/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL, (Specify): <u>Burial</u>	DATE THEREOF <u>April 11, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Schwartz's</u>	LOCATION (City, town, or county) (State) <u>Baltimore</u>
DATE REC'D BY LOCAL REG. <u>4-11-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Lilly & Zeiler Inc., 403 S. Wolfe St.</u>	

1583

1583



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
52 TOWN <u>Catonsville</u>		TOWN <u>Baltimore</u> 3001.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
90 <u>Ridgeway Nursing Home</u>		522 Rock Glen Rd. ✓	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) (Middle) (Last)		April 27 19 55	
LOUISE DILL			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
female	white	widowed	July 31, 1873
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
81 yrs.		Md.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		12. CITIZEN OF WHAT COUNTRY?	
never worked			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Frederick A. Kaupp		Justine Kleinhenn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
no		Miss Justine C. Dashner-526 Swann Ave.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.0			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>			2 yrs.
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Carcinoma of Stomach</u>			4 month
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>53</u> , to <u>April 27</u> 19 <u>55</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>55</u> and that death occurred at <u>2:30</u> AM, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>For J. Gava</u> M.D. Baltimore, Md.		4/27/55	
23. BURIAL CREMATION REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Removal-Burial		Arlington National Cem.	
DATE THEREOF		LOCATION (City, town, or county) (State)	
4/29/55		Arlington, Va.	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
4/28/55		<u>Thos. J. Pickens & Son - Balt.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CHRISTIANITY OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

3404
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03376

No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> LENGTH OF STAY (in this place) <u>18yr. 2mo. 13days</u> TOWN <u>Catonsville</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u> 3401-4 TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>707 S. Decker Avenue</u>			
3. NAME OF DECEASED: (Type or Print) <u>Pauline</u> (First) (Middle) (Last) <u>Dlugoborska</u>				4. DATE OF DEATH <u>April 25,</u> 19 <u>55</u> (Month) (Day) (Year)			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>1-26-1892</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME: <u>Alexander Redyk</u>				14. MOTHER'S MAIDEN NAME: <u>Victoria ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			

18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Coronary thrombosis</u> DUE TO Antecedent cause(s) (b) <u>Arteriosclerotic cardiovascular disease</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Years</u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mental Illness</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Geo. M. Kieffer</u>		1010 <u>Redman</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>4-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>April 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REG. <u>Apr. 27, 1955</u>		REGISTRAR'S SIGNATURE <u>H. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Fred W. Ozarewski</u>		ADDRESS <u>1930 Eastern Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

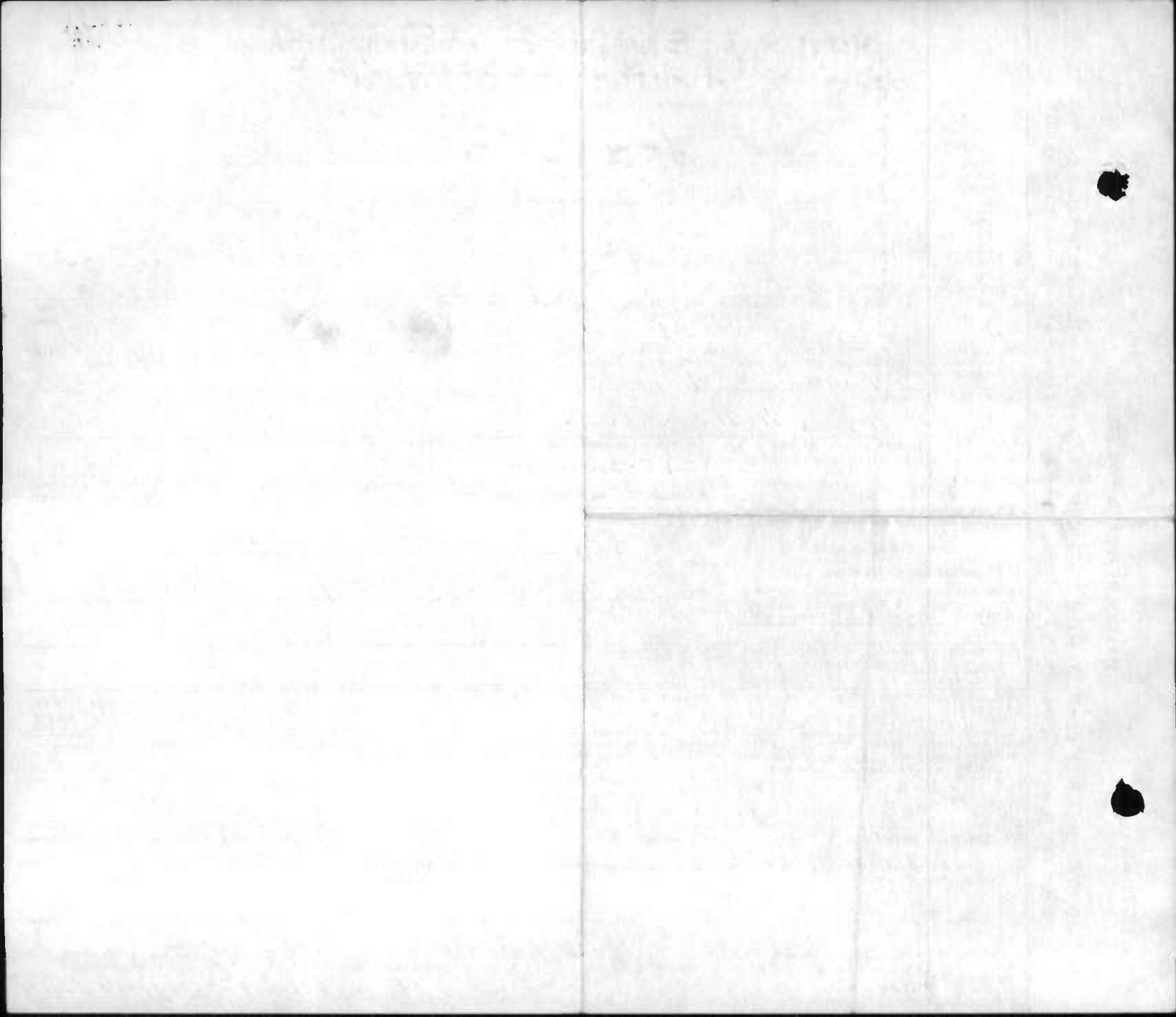
03377

3405

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Balto.</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <i>Lutherville</i>	LENGTH OF STAY (in this place) <i>2 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Lutherville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00 Bellona Ave</i>	STREET ADDRESS (If rural give location) <i>Bellona Ave</i>		
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Cassandra Dorsey</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>April 6 1955</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>M</i>	8. DATE OF BIRTH: <i>18 June 1880</i>
9. AGE last birthday: <i>74</i> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country): <i>Hartford Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>William Henry Jones</i>		14. MOTHER'S MAIDEN NAME: <i>Edsabeth Johnson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-32-1171</i>	
17. INFORMANT & ADDRESS: <i>2 Ensor Ave</i>		<i>Daughter - Sarah C. Williams Towson Md</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>			<i>2 hours</i>
ANTECEDENT CAUSE (B) <i>Hypertensive Arteriosclerotic CV Disease</i>			<i>over 8 months</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 1954</i> to <i>6 April 1955</i> , that I last saw the deceased alive on <i>31 March 1955</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Walter T. Kees</i>		ADDRESS <i>Cockeysville, Md.</i> DATE SIGNED <i>6 April 1955</i>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <i>Burial</i>		DATE THEREOF <i>April 9, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Pleasant Rest</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Co., Ind.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>April 9, 1955</i>		REGISTRAR'S SIGNATURE <i>R. W.</i>	
24. FUNERAL DIRECTOR		ADDRESS <i>Holland Funeral Home - 1631 David Hill Ave.</i>	



3406

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
54 <u>TOWN Baltimore, Md.</u>				54 <u>TOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <u>Katherine Robb Nursing Home</u>				1 <u>Essex Rd. Balto 7, Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Bertie Estelle Dunn</u>				OF <u>April 19</u> 19 <u>55</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>6-15-82</u>	
9. AGE last birthday: <u>72</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Allen (first name unknown)</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Son 3526 Essex Rd. Balto 7, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
442X IMMEDIATE CAUSE (A) <u>Uremia</u>		3 wks	
ANTECEDENT CAUSE (S) (B) <u>Hypertensive C/V Renal Disease</u>		10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>		5 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
--	--	--	--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
---	--	--	--	----------------------------	--

22. I hereby certify that I attended the deceased from 6/15, 1953, to 4/19, 1955, that I last saw the deceased alive on 4/16, 1953, and that death occurred at 9 A. M, from the causes and on the date stated above. 55
 SIGNATURE Edwin G. Simpson M. D. ADDRESS 8204 Liberty Rd DATE SIGNED 4-19-55

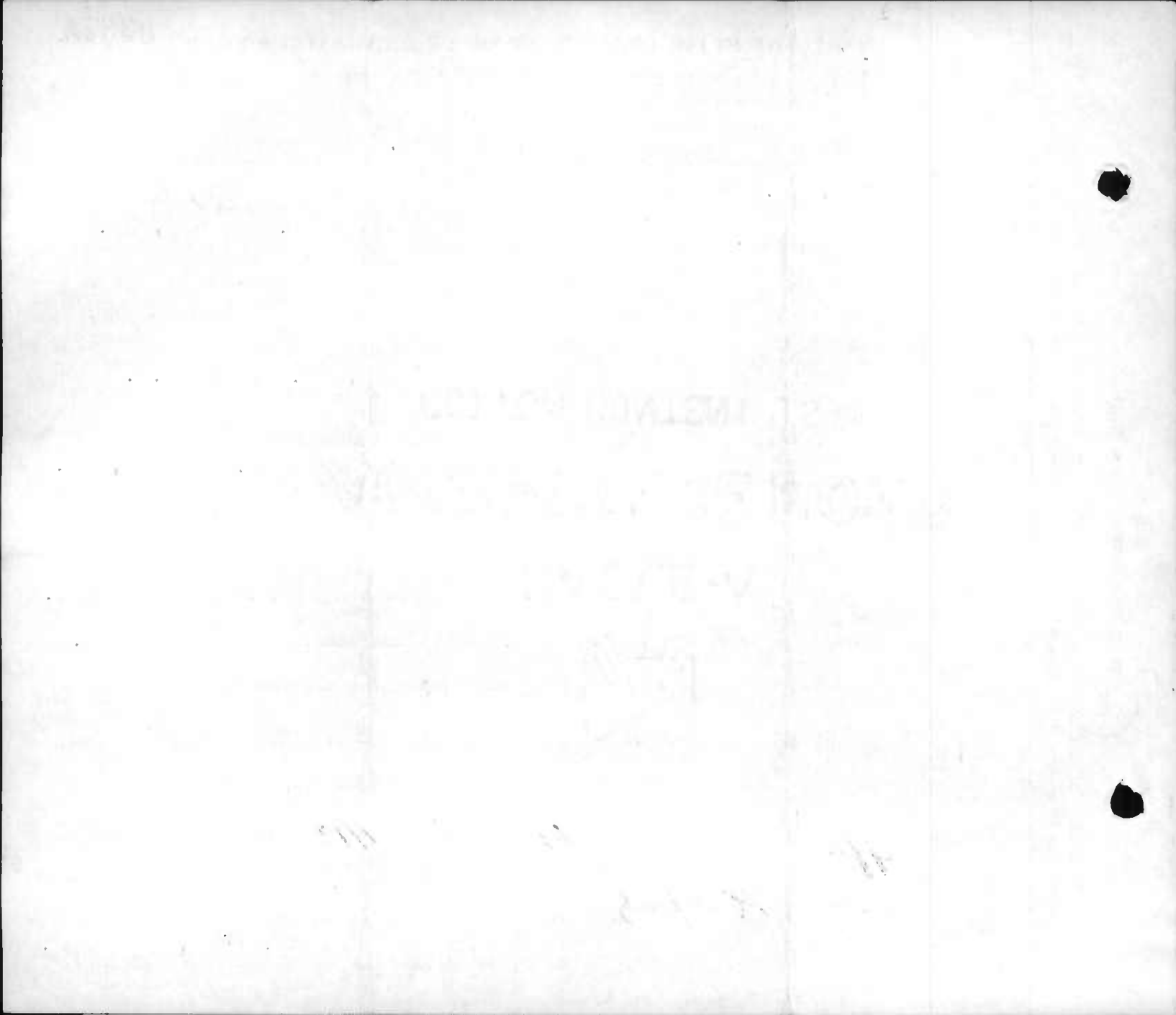
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 21/55</u>		<u>Woodlawn Cemetery</u>		<u>Baltimore 7, Md.</u>	

DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-20-55</u>		<u>a w Hedrick</u>		<u>Loring Byers</u>		<u>5005 Plethys Baltimore 15, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **03379**
3497 **CERTIFICATE OF DEATH**

Reg. Dist. No. **21**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore Co.		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN Granite		37 yrs.		TOWN Granite		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Davis Avenue				STREET ADDRESS (If rural give location) Davis Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
GEORGE A. ELLWOOD				DATE OF DEATH: Apr. 5th., 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Dec. ? 1879	
9. AGE last birthday 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employed Farmer		11. BIRTHPLACE (State or foreign country): Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS: Mrs. Anna Ellwood Davis Ave. Granite, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE						1 day	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Cerebral hemorrhage							
DUE TO							
(B) Cardio Vascular Disease							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/5/55 , 1955, to 4/5/55 , 1955, that I last saw the deceased alive on 4/5/55 , 1955, and that death occurred at 11:00 M, from the causes and on the date stated above.							
SIGNATURE Wm. E. Martin		ADDRESS Pandalltown Md		DATE SIGNED 4/6/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/8/55		NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		LOCATION (City, town, or county) (State) Laurel, Md.	
DATE REC'D BY LOCAL REGISTRAR 4/6/55		REGISTRAR'S SIGNATURE Wm. E. Martin		24. FUNERAL DIRECTOR E. Aston Rome		ADDRESS Catonsville, Md.	

RECEIVED
APR 11 1955
BUREAU V. S.

29-53

3408

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03380

CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 9, film 180 4-19-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u> MARYLAND				STATE <u>Md.</u> COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL or nearest town) <u>52 Catonsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Burnie</u> 02X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp.</u>				STREET ADDRESS (If rural, give location) <u>5th Ave</u>			
3. NAME OF DECEASED: (Type or Print) <u>Mattie M. Elswick</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>4-8-1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH: <u>9-19-1880</u>	9. AGE last birthday <u>74</u> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unemployed</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>	
13. FATHER'S NAME: <u>Abraham Moore</u>				14. MOTHER'S MAIDEN NAME: <u>Susan Brammer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs Henry Siegert, Pasadena, Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>						<u>few hours</u>	
ANTECEDENT CAUSE (S) <u>Cardiac failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-7</u> , 1955, to <u>4-8</u> , 1955 that I last saw the deceased alive on <u>4-8</u> , 1955, and that death occurred at <u>7:30</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>730 a.m.</u>		DATE SIGNED <u>4-8-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen HAVEN</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/13/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>Hopping & KIRKLEY, Glen Burnie, Md</u>			
April 9, 1955							

MARGIN RESERVED FOR BINDING

VS. A15 -- 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 13 1955

RECEIVED

3409

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Parkton</i>	STATE <i>Maryland</i> COUNTY <i>Baltimore</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Parkton</i>
OR TOWN <i>Parkton</i>	LENGTH OF STAY (in this place) <i>2 yrs.</i>	OR TOWN <i>Parkton</i>	STREET ADDRESS (If rural give location) <i>Main St.</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Main St.</i>		STREET ADDRESS <i>Main St.</i>	
3. NAME OF DECEASED: (First) <i>Margaret</i> (Middle) <i>Ensor</i> (Last) <i>Ensor</i>		4. DATE (Month) (Day) (Year) OF DEATH <i>April 23, 1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>Jan 1, 1873</i>
9. AGE last birthday <i>82</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Lorraine, Ohio.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Own Home.</i>	
11. BIRTHPLACE (State or foreign country): <i>Lorraine, Ohio.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Frank Mackert.</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No. <i>Unknown.</i>	
17. INFORMANT & ADDRESS: <i>Mrs Gertrude Bauer, Parkton Md.</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
442X IMMEDIATE CAUSE (A) <i>Cardiovascular renal disease</i>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to <i>4/23/55</i> 19....., that I last saw the deceased alive on <i>4/22/55</i> , 19....., and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>C. M. France</i>		DATE SIGNED <i>9/23/55</i>	
ADDRESS <i>Parkton Md.</i>		M. D. <i>Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>April 26/1955</i>	
NAME OF CEMETERY OR CREMATORY <i>MonktonMeth Cem.</i>		LOCATION (City, town, or county) (State) <i>Monkton, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4/27/55</i>		REGISTRAR'S SIGNATURE <i>Mrs Howard S. Marklin</i>	
FUNERAL DIRECTOR <i>Paul Fortenstein</i>		ADDRESS <i>New Freedom, Pa.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 2 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3410		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		03382 Reg. Dist.	
Item 18 filed 4-15-55					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 30					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Harp.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (In this place) <u>12 HRS.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>HAURE DE GRACE</u> <u>12X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE HOSP. CATONSVILLE 28, MD.</u>		STREET ADDRESS (If rural, give location) <u>ROUTE #2</u> ✓			
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) (Middle) (Last) <u>NELLIE BENNETT EPSTEIN</u>			(Month) (Day) (Year) <u>APRIL 3 19 55</u>		
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	
8. DATE OF BIRTH: <u>UNK.</u>		9. AGE last birthday: <u>39?</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>UNK</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>UNK.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			13. FATHER'S NAME: <u>UNK</u>		
14. MOTHER'S MAIDEN NAME: <u>UNK.</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>UNK.</u>		
16. SOCIAL SECURITY No.:			17. INFORMANT & ADDRESS: <u>FRED BENNETT ROUTE #2 HAURE DE GRACE MD.</u>		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause DUE TO <u>Decubital Pneumonia</u>					
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO <u>Oedema of the Brain</u>					
(c) stating underlying cause last DUE TO					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>3-31-55 took 22 grs nembutal never regained consciousness</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Dr. M. Kieffer</u>		1010 Leede on		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>April 3 55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>4/3/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Woodland Cemetery</u>	
LOCATION (City, town, or county) (State): <u>Forsythe Co. N.C.</u>		24. FUNERAL DIRECTOR: <u>H. Madison Mitchell</u>		ADDRESS: <u>Haure de Grace, Md.</u>	
DATE REC'D. BY LOCAL REG. <u>4/3/55</u>		REGISTRAR'S SIGNATURE: <u>V.E. Harry</u>			

RECEIVED

APR 5 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

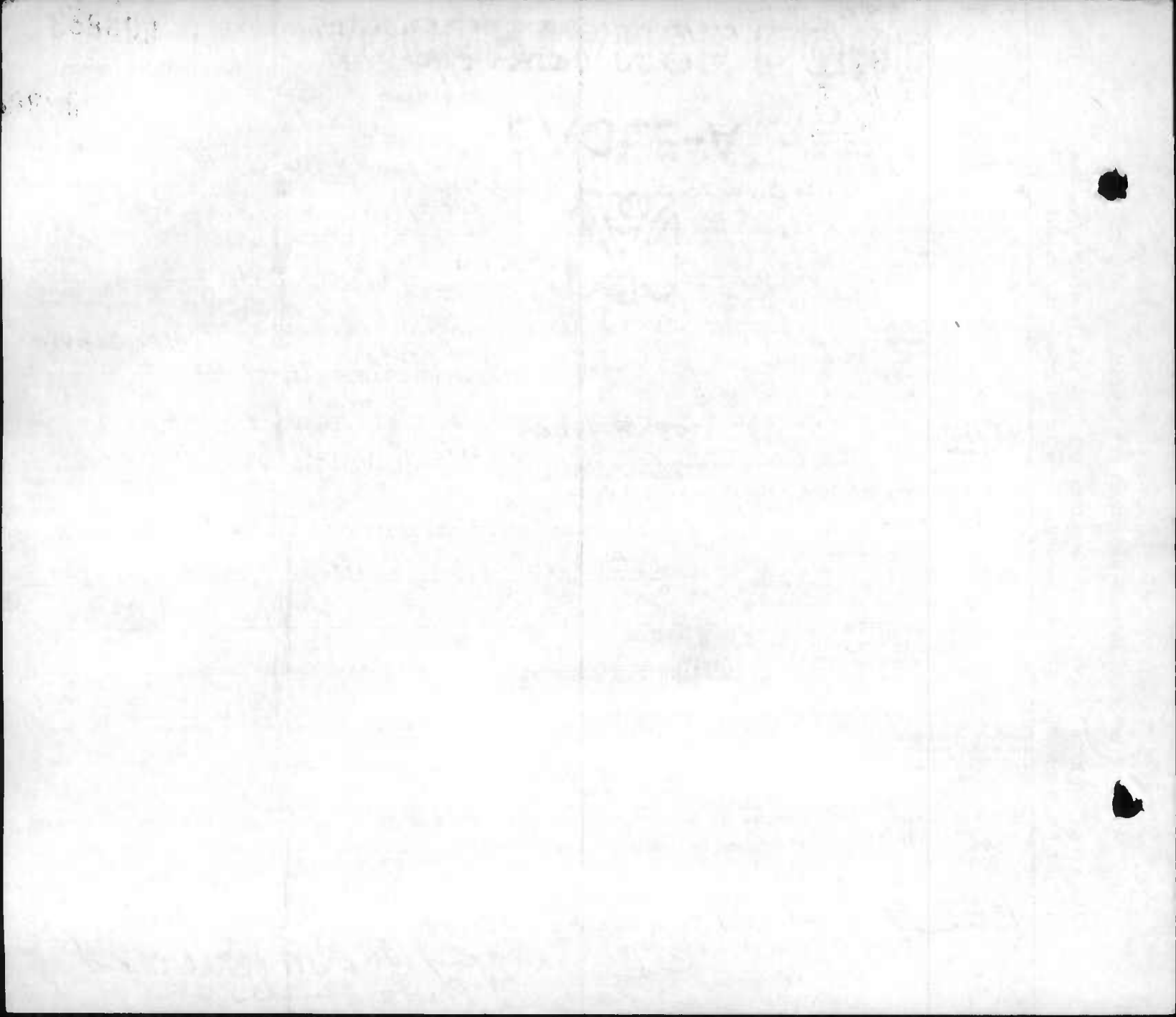
03383

3411

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place) <u>8/24/54</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore #23</u>	<u>34014</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>	STREET ADDRESS (If rural give location) <u>1425 Ms Henry St.</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Sam</u>	(Middle) <u>-</u>	(Last) <u>Evins</u>	DEATH: <u>4</u> <u>11</u> <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>m.</u>	8. DATE OF BIRTH: <u>2.8.1888</u>
9. AGE last birthday: <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>unk.</u>	
11. BIRTHPLACE (State or foreign country): <u>Yugoslavia</u>		12. CITIZEN OF WHAT: <u>unknown</u>	
13. FATHER'S NAME: <u>Yreta Evins</u>		14. MOTHER'S MAIDEN NAME: <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service): <u>unk.</u>		16. INFORMANT & ADDRESS: <u>This Hospital's Records</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>420.0</u>		<u>unknown</u>	
ANTECEDENT CAUSE (S)		<u>few years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>few years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/24</u> , 19 <u>54</u> , to <u>4/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>55</u> , and that death occurred at <u>6:20 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Bruno Radauskas</u>		DATE SIGNED <u>4/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
DATE THEREOF <u>4/13/55</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>4-12-55</u>		REGISTRAR'S SIGNATURE <u>Dr. W. Hedrick</u>	
25. ADDRESS		26. ADDRESS	
<u>1425 Ms Henry St.</u>		<u>1425 Ms Henry St.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03384
3412 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Catonsville</u>		5 mo. 18 days		TOWN <u>North Beach</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Spring Grove State Hospital</u>							
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH			
<u>Edward B. Finch</u>				<u>April 1, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>12-13-1883</u>	<u>71</u> yrs	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Elevator constructor</u>						<u>Washington, D. C.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James Finch</u>				<u>Emma Fitnam</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Unknown</u>				<u>Unknown</u>		<u>Records Spring Grove State Hospital</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Diffuse nodular cirrhosis of liver</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.				(B) <u>Arteriosclerotic cardiovascular disease</u>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING DEATH.							
<u>Arteriosclerotic cardiovascular disease</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?							
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-14-, 1954</u> to <u>4-1-, 1955</u> that I last saw the deceased alive on <u>4-1-, 1955</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.							
SIGNATURE		DATE SIGNED		ADDRESS			
<u>S. Wachsler</u>		<u>4-1-55</u>		<u>Spring Grove State Hospital</u>		<u>4-1-55</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATOR		LOCATION (City or town) (County) (State)	
<u>Burial</u>		<u>4/4/55</u>		<u>Mt. Olivet Cemetery</u>		<u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4/2/55</u>		<u>V. E. Harris</u>		<u>T. F. Costello</u>		<u>1722 - N. Capital St. Wash. D. C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 4 1955

RECEIVED

RECEIVED
COMMUNICATIONS
DIVISION
APR 4 1955

MARYLAND STATE DEPARTMENT OF HEALTH

03385

3413

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bowleys Quarters		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bowleys Quarters	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 291C Route 15				STREET ADDRESS Box 291C Route 15 Baltimore 20	
3. NAME OF DECEASED (Type or Print) Alfred		(First) (Middle) W. (Last) Fischer		4. DATE (Month) (Day) (Year) OF DEATH April 15 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov 29, 1899	9. AGE last birthday 55 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool and Die Maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Jacob Fischer		14. MOTHER'S MAIDEN NAME Maria Ertel		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS Mrs Frances Fischer Bowleys Quarters, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

2001
Immediate cause

(a)

Lymphosarcoma of lung

Antecedent cause(s)

(b)

Metastases

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒TIME (Month) (Day) (Year) (Hour)
OF INJURY m.INJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/9 1954, to present 1955, that I last saw the deceased alive on 4/12 1955, and that death occurred at 9 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-18-55

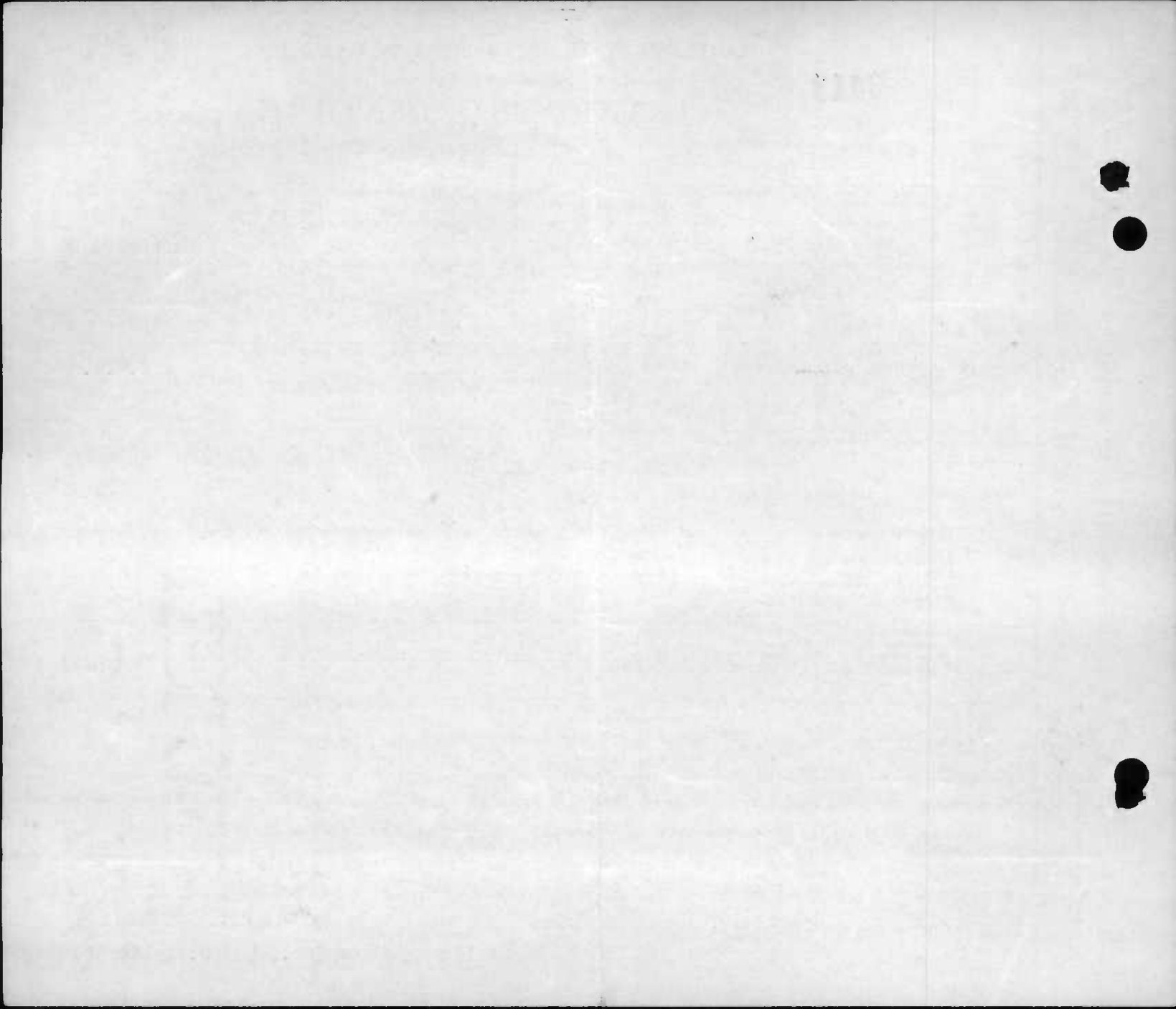
aw Bednick

Lilly & Zeiler Inc., 403 S. Wolfe St.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3414

CERTIFICATE OF DEATH

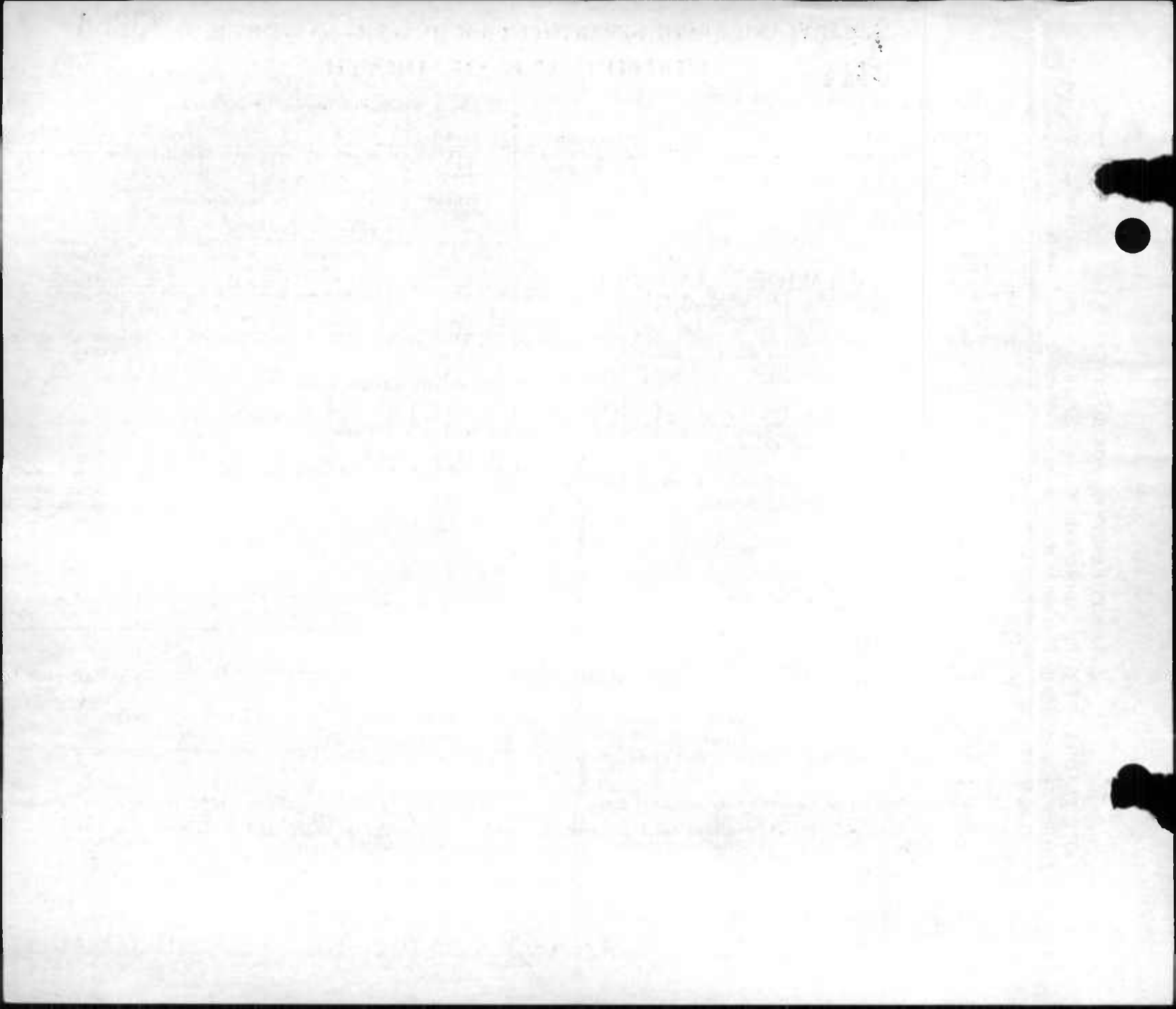
Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>(RURAL) BALTIMORE</u>				TOWN <u>ECCLESTON</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		/	
90 <u>MERCY VILLA</u>				<u>"THE CAVES"</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print) <u>KATHARINE</u>		<u>LE MOYNE</u> <u>FISHER</u>		<u>APRIL</u> <u>26</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>WIDOWED</u>	<u>SEPT. 19, 1866</u>	<u>88</u>	Yrs.	Months	Days
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>OWN HOME</u>		<u>MD.</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>JOHN VALCOULON LEMOYNE</u>				<u>JULIA MURRAY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
				<u>D.R.A.M. FISHER, RUXTON, 5 MD. BOX 105</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
355X Immediate cause (a) <u>Arteriosclerosis</u>						?	
Antecedent causes (s) (b) <u>Diverticulitis</u>						?	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Huntington's Chorea</u>						25 yrs.	
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1945 to 1955, that I last saw the deceased alive on <u>Apr. 25, 1955</u> , and that death occurred at <u>Mercy Villa, Balto. City</u> from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>A. Murray Fisher, M.D.</u>		<u>M.D.</u>		<u>18 E. Eager St. Balto.</u>		<u>4/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>APR. 26, 1955</u>		<u>GREENMOUNT</u>		<u>BALTO. MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-22-55</u>		<u>[Signature]</u>		<u>H.W. JENKINS & SONS CO.</u>		<u>4905 YORK ROAD BALTO. 12 MD</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



03387

MARYLAND STATE DEPARTMENT OF HEALTH

3354

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 41 32

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>BALTO.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK 22</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - PATESVILLE</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOLY ROSARY CEMETERY</u> <u>GERMAN HILL Rd.</u>		STREET ADDRESS (If rural, give location) <u>4016 VILHA NOVA RD. VILHA NOVA</u>	
3. NAME OF DECEASED (Type or Print) <u>HERMAN W. FLERLAGE</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>20</u> (Year) <u>1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>MARCH 1879</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>
13. FATHER'S NAME <u>WILLIAM FLERLAGE</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>705-07-9227</u>	
		17. INFORMANT AND ADDRESS <u>THEODORE FLERLAGE</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Crown Occlusion</u> Antecedent cause(s) (b) <u>Diseases nr conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input type="checkbox"/> HOW DID INJURY OCCUR	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>M. S. Davis</u>		DATE SIGNED <u>4/20/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>APRIL 23, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY</u>		LOCATION (City, town, or county) (State) <u>DUNDALK MD</u>	
DATE REC'D BY LOCAL REG. <u>4/27/55</u>		24. FUNERAL DIRECTOR <u>Frank H. Newell</u>	
REGISTRAR'S SIGNATURE <u>Am. M. Kelly</u>		ADDRESS <u>1160 HEISTERS PATESVILLE</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 27 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03388

3415

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>22 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove St. Hosp.</u>				STREET ADDRESS (If rural give location) <u>The Terraces, Mt Washington</u>			
3. NAME OF DECEASED: (Type or Print) <u>Nettie F. Foster</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>4</u> <u>5</u> <u>1955</u>			
5. SEX: <u>f</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S.</u>	8. DATE OF BIRTH: <u>5. 25. 1871</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>librarian retired</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Md</u>	
13. FATHER'S NAME: <u>William Foster</u>				14. MOTHER'S MAIDEN NAME: <u>Marian Robinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE						(A) <u>Coronary Thrombosis with chronic myocarditis</u> <u>unknown</u>	
ANTECEDENT CAUSE (S):						(B) <u>Hypertensive cardiovascular disease</u> <u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(C) <u>Pyelitis</u> <u>unknown</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3. 14.</u> , 19 <u>55</u> , to <u>4. 5.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4. 4.</u> , 19 <u>55</u> , and that death occurred at <u>5. 4</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Gertrude J. Fleischman</u>		ADDRESS <u>M.D. Spring Grove St. Hosp.</u>		DATE SIGNED <u>4.5.55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>Apr. 7-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-6-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Redlich</u>		24. FUNERAL DIRECTOR <u>Wm Cook Inc</u>		ADDRESS <u>1217 St Paul St</u>	

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03389

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3416

Item 22, Film 180 4-18-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
X TOWN <u>Fort Howard, Maryland</u>		<u>449 Days</u>		<u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 Veterans Administration Hospital</u>				<u>850 W. 34th Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH:			
<u>WILLIAM T. FRANTOM</u>		<u>April 8</u>		<u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>10/5/88</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Garden work</u>		<u>Landscaping</u>		<u>Carroll Co., Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Joseph Frantom</u>				<u>Annie Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes</u> <u>WW-I</u>				<u>216 10 9394</u>		<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1999 IMMEDIATE CAUSE (A) <u>METASTATIC CARCINOMA WITH TRACHEO-ESOPHAGEAL FISTULA</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>VA</u>		<u>M.</u>		<u>54</u>			
22. I hereby certify that I attended the deceased from <u>Jan. 14, 1955</u> to <u>April 8, 1955</u> and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>GEORGE LERNER, M.D.</u>		<u>VAH, Fort Howard, Md.</u>		<u>4-9-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>APRIL 12, 1955</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4/11/55</u>		<u>A.P. Dedrick</u>		<u>William Cook-Blight Inc</u>		<u>6009 Harford, Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

January 1, 1914

Mr. J. H. ...

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully, yours, very truly, J. H. ...

Very truly yours, J. H. ...

Enclosed for you are two copies of the report of the ...

...

...

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...

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...

...

3355

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write OR and give nearest town) Dundalk RURAL LENGTH OF STAY (in this place) years
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 3428 Solbus Pt. Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore
 CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk OR TOWN 53
 STREET ADDRESS (If rural give location) 3428 Solbus Pt. Rd.

3. NAME OF DECEASED:

(First) Grover (Middle) Cleveland (Last) Fritz
 (Type or Print)

4. DATE OF DEATH: (Month) 4 (Day) 13 (Year) 1955

5. SEX:

5. COLOR OR RACE: male white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Aug. 7-1885

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: farmer

10b. KIND OF BUSINESS OR INDUSTRY: tenant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME:

Alexander Fritz

14. MOTHER'S MAIDEN NAME:

Margaret Hooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 215-26-1148

17. INFORMANT & ADDRESS: W.C. Fritz, Dundalk, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Chronic Myocarditis

DUE TO

(c)

Interval Between Onset And Death
10 yrs.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-23, 1955, to 4-13, 1955; that I last saw the deceased

alive on 4-7, 1955, and that death occurred at 10:20 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 18-1955

William M. Kelly

D. D. Hartzler & Sons

New Windsor, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 20 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03391

Reg. Dist. No. 38

Wed. 9.00 3417

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenview Rd</u>		STREET ADDRESS (If rural, give location) <u>Towson</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Sister Mary Meta Gaugler</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 10 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 10, 1868</u>
9. AGE last birthday <u>86</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Wurtemberg Germany</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Gaugler</u>		14. MOTHER'S MAIDEN NAME <u>Mary Baumgartner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
442 Immediate cause (a) <u>Hypertensive cardiac renal vascular disease</u>		25 yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____		
(c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 3, 1955, to April 10, 1955, that I last saw the deceased alive on April 3, 1955, and that death occurred at 5:25 P.m., from the causes and on the date stated above.

SIGNATURE <u>William A. Priestley</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Towson</u>	DATE SIGNED
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>4-13-55</u>	NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM. NOTCH CLIFF NR TOWSON</u>	LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
DATE REC'D BY LOCAL REG. <u>4-12-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Charles S. Guler</u>	ADDRESS <u>901 S. CONKLIN ST. BALTO. MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3362
CERTIFICATE OF DEATH

03392

Reg. Dist. No. 42

1. PLACE OF DEATH: COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Arbutus TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 4111 Wilkens Ave				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Arbutus TOWN STREET ADDRESS 4111 Wilkens Ave			
3. NAME OF DECEASED: (First) John J. (Middle) Glick (Last)				4. DATE OF DEATH: (Month) Apr. (Day) 21 (Year) 1955			
5. SEX: male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH: Oct. 19, 1883	
9. AGE last birthday: 71 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Rest. Owner				10b. KIND OF BUSINESS OR INDUSTRY: Rest. Owner		11. BIRTHPLACE (State or foreign country): Baltimore	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME: John Glick				14. MOTHER'S MAIDEN NAME: Barbara Spahn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: 212-30-5509		17. INFORMANT & ADDRESS: Anna G. Glick, 4111 Wilkens Ave			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) Sudden + Complete Coronary Occlusion DUE TO Antecedent cause(s) (b) Arteriosclerotic C.V. Disease DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH Immediate ?	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec , 19 47 , to April 21 , 19 55 , that I last saw the deceased alive on April 21 , 19 55 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. SIGNATURE John T. Coalahan, M.D. (DEGREE OR TITLE) ADDRESS 4201 Wilkens Ave DATE SIGNED 4/22/55							
23. BURIAL, CREMATION REMOVAL (Specify): Burial		DATE THEREOF: 4-25-55		NAME OF CEMETERY OR CREMATORY: New Cathedral		LOCATION (City, town, or county) (State): Baltimore, Md.	
DATE RECD BY LOCAL REG: April 13, 55		REGISTRAR'S SIGNATURE: Geo. Tieffer		24. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave ADDRESS			

BUREAU V. 1

APR 25 1955

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3418

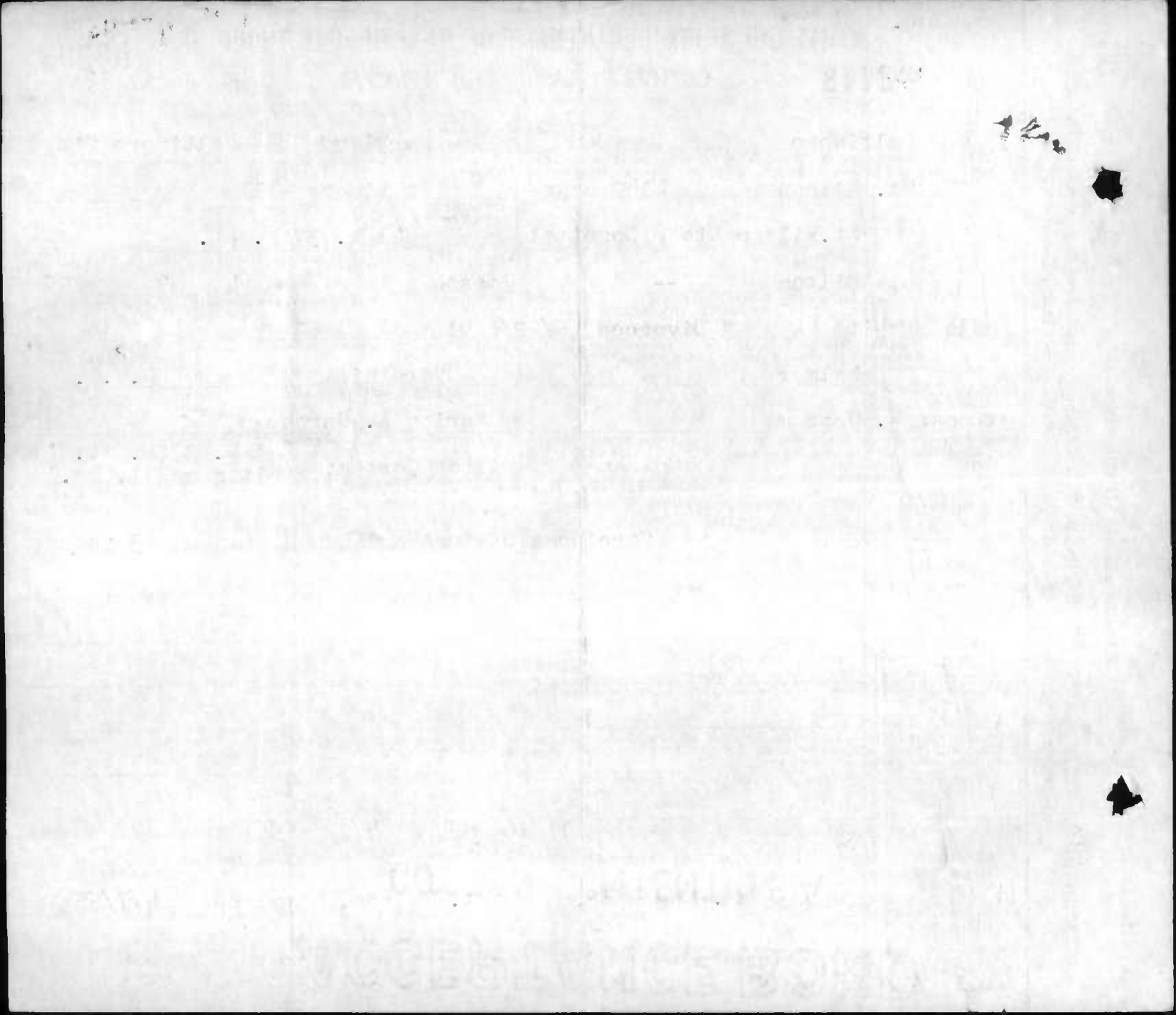
CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u> City
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Mt. Wilson</u>	<u>142</u> days	TOWN <u>Baltimore - 11</u> <u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>02</u> <u>Mt. Wilson State Hospital</u>		<u>841 W. 37th. St.</u> <u>✓</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>4</u> <u>7</u> <u>19 55</u>	
<u>Milton</u> <u>Edwin--</u> <u>Gossom</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Divorced</u>	<u>5/22/1891</u>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>63</u> yrs.		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Embalmer</u>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Thomas E. Gossom</u>		<u>Marion A. Garner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>220-09-5012</u>	
17. INFORMANT & ADDRESS:			
<u>Milton Gossom,</u>		<u>841 W. 37th. St.</u>	
		<u>Baltimore 11, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>163X</u>			
IMMEDIATE CAUSE (A) <u>Carcinoma of Lung</u>			<u>3 years</u>
DUE TO			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
OF INJURY		While <input type="checkbox"/> Not while <input type="checkbox"/>	
		at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11/16</u> , 19 <u>54</u> , to <u>4/7</u> , 19 <u>55</u> that I last saw the deceased alive on <u>4/7</u> , 19 <u>55</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>William Newcomer</u>		<u>4/7/55</u>	
WM. NEWCOMER, M. D. Mt. Wilson, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Druid Ridge Cem.</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>Apr. 12, 55</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>April 9, 1955</u>		<u>Ellsworth Armistead</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>R.W.</u>		<u>4600 Liberty High</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3419

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Catonsville</i>		LENGTH OF STAY (in this place) <i>2 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>BERWYN, Md.</i>		<i>16 X-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Spring Grove State Hosp.</i>				STREET ADDRESS (If rural give location) <i>9412 Baltimore Ave.</i>			
3. NAME OF DECEASED: (Type or Print) <i>SAMUEL JACKSON GRADY</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>APRIL 11 1955</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>Sep.</i>	8. DATE OF BIRTH: <i>7 1882</i>	9. AGE last birthday: <i>71</i> yrs	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Gov't emp.</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>—</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
13. FATHER'S NAME: <i>Jas. P. Grady</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>?</i>				14. MOTHER'S MAIDEN NAME: <i>Mary Jane</i>			
16. SOCIAL SECURITY NO. <i>?</i>				17. INFORMANT & ADDRESS: <i>Mrs. Lorraine Barrett (above address)</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>154X</i>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <i>Respiratory failure associated with intra cerebral hemorrhage possibly.</i>						<i>about 1 wk.</i>	
(B) <i>Metastatic malignant tumor of brain</i>						<i>?</i>	
(C) <i>Primary adenocarcinoma of rectum & colon in involvement of prostate, lungs, and probably cerebellum.</i>						<i>2 years.</i>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>Sept, 1953</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Adenocarcinoma of rectum, bowel resection and colectomy</i>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4/24</i> , 19 <i>53</i> to <i>4/11</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4/11</i> , 19 <i>55</i> , and that death occurred at <i>6:20 p. M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Linda Day</i>		M. D. <i>Spring Grove St. Hosp.</i>		DATE SIGNED <i>4/11/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>4/15/55</i>		NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>		LOCATION (City, town, or county) (State) <i>Colmar Manor Md</i>	
DATE REC'D BY LOCAL REGISTRAR: <i>April 14 1955</i>		REGISTRAR'S SIGNATURE <i>T.E. Harry</i>		24. FUNERAL DIRECTOR <i>F. Gaschi Sons</i>		ADDRESS <i>Nyctanille, Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 19 1955

BUREAU V. B.

3420

item 8 film 181 5-3-55 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03395 Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN BALTO. 12 -		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore 12		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 712 WALKER AVE.				STREET ADDRESS (If rural, give location) 712 Walker Avenue			
3. NAME OF DECEASED: (First) MARY		(Middle) ELIZABETH		(Last) GUNN		4. DATE OF DEATH (Month) 4 (Day) 11 (Year) 19 55	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED DEC. 12, 1864		8. DATE OF BIRTH: 1874 9. AGE last birthday: 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME		11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: JOHN AXER				14. MOTHER'S MAIDEN NAME: SUSANNA HECK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO		(If Yes, give war or dates of service) NONE		16. SOCIAL SECURITY No.: NONE		17. INFORMANT & ADDRESS: 712 WALKER AVE. MRS ROSALIE BERRY BALTO. 12, MD.	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Confluent bronchopneumonia, right upper, and middle lobes Antecedent cause(s) (b) Organizing empyema, right thorax Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? partial			
22. I hereby certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE W. C. Updegraff		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/12/55					
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL		DATE THEREOF APR. 14, 1955		NAME OF CEMETERY OR CREMATORY ROCK SPRING CEMETERY		LOCATION (City, town, or county) (State) FOREST HILL, HARFORD CO., MD.	
DATE REC'D BY LOCAL REG. April 14, 1955		REGISTRAR'S SIGNATURE Mabel C. Gray		24. FUNERAL DIRECTOR John Burnie Lane, Towson, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 15 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **03396**

3421 CERTIFICATE OF DEATH

Reg. Dist. No. **38**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Stoneleigh			
X TOWN Stoneleigh				STREET ADDRESS (If rural give location) 605 Kingston Road			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 605 Kingston Road							
3. NAME OF DECEASED: (Type or Print)		(First) Robert		(Middle) Adams		(Last) Harp	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: July 14, 1942	
				9. AGE last birthday: 12 yrs.		4. DATE (Month) (Day) (Year) OF DEATH: April 17, 1955	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME: Maynard E. Harp				14. MOTHER'S MAIDEN NAME: Retta Elizabeth Potter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Maynard E. Harp 605 Kingston Road			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
237X IMMEDIATE CAUSE (A) Hydrocephalus							
ANTECEDENT CAUSE (S): (B) Brain Tumor							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Convulsions							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 10, 1952 , to April 17, 1955 , that I last saw the deceased alive on April 17, 1955 , and that death occurred at 1:30 AM , from the causes, and on the date stated above.							
SIGNATURE Laurence C. Tash		ADDRESS 6805 York Rd Baltimore Md		DATE SIGNED 4/18/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 18, 1955		NAME OF CEMETERY OR CREMATORY Prospect Hill		LOCATION (City, town, or county) (State) Towson, Md.	
DATE REC'D BY LOCAL REGISTRAR 4-18-55		REGISTRAR'S SIGNATURE E. W. Schuch		24. FUNERAL DIRECTOR Wm J. Tickner		ADDRESS Home 7714 Baltimore	

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3422 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03397			
CERTIFICATE OF DEATH			
Reg. Dist. No. 30			
Item 11, Film 180 4-19-55 et			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore (17)</u>	✓
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove St. Hosp.</u>		STREET ADDRESS (If rural give location) <u>2311 Callow Ave 3401-4</u>	
3. NAME OF DECEASED: (First) <u>Shinnie</u> (Middle) <u>C.</u> (Last) <u>Helfrich</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>4</u> <u>9</u> <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>11. 8. 1880</u>
9. AGE last birthday <u>74</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>
13. FATHER'S NAME: <u>Nicholas</u>		12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME: <u>Elizabeth Fillinger</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <u>570.3</u> (A) <u>Volvulus of sigmoid colon</u>			<u>hours</u>
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>DUE TO</u>			
(C) <u>DUE TO</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/29</u> , 19 <u>55</u> , to <u>4/9</u> , 19 <u>55</u> that I last saw the deceased alive on <u>4/9</u> , 19 <u>55</u> , and that death occurred at <u>11:54</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>S. Wachter</u>		DATE SIGNED <u>4/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-13-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mellinger Mennonite Cem.</u>		LOCATION (City, town, or county) (State) <u>Lancaster, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/10/55</u>		REGISTRAR'S SIGNATURE <u>H.E. Harry</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Jaime Funeral Home, 317 E. Orange St. Lancaster, Pa.</u>	

BUREAU V. S.

APR 12 1955

RECEIVED

RECEIVED
JULY 25 1963
U.S. AIR FORCE
HARRISBURG, PENNSYLVANIA
OFFICE OF THE
DIRECTOR, AIR FORCE
RESEARCH AND
DEVELOPMENT
HARRISBURG, PENNSYLVANIA

MARYLAND STATE DEPARTMENT OF HEALTH

03399

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

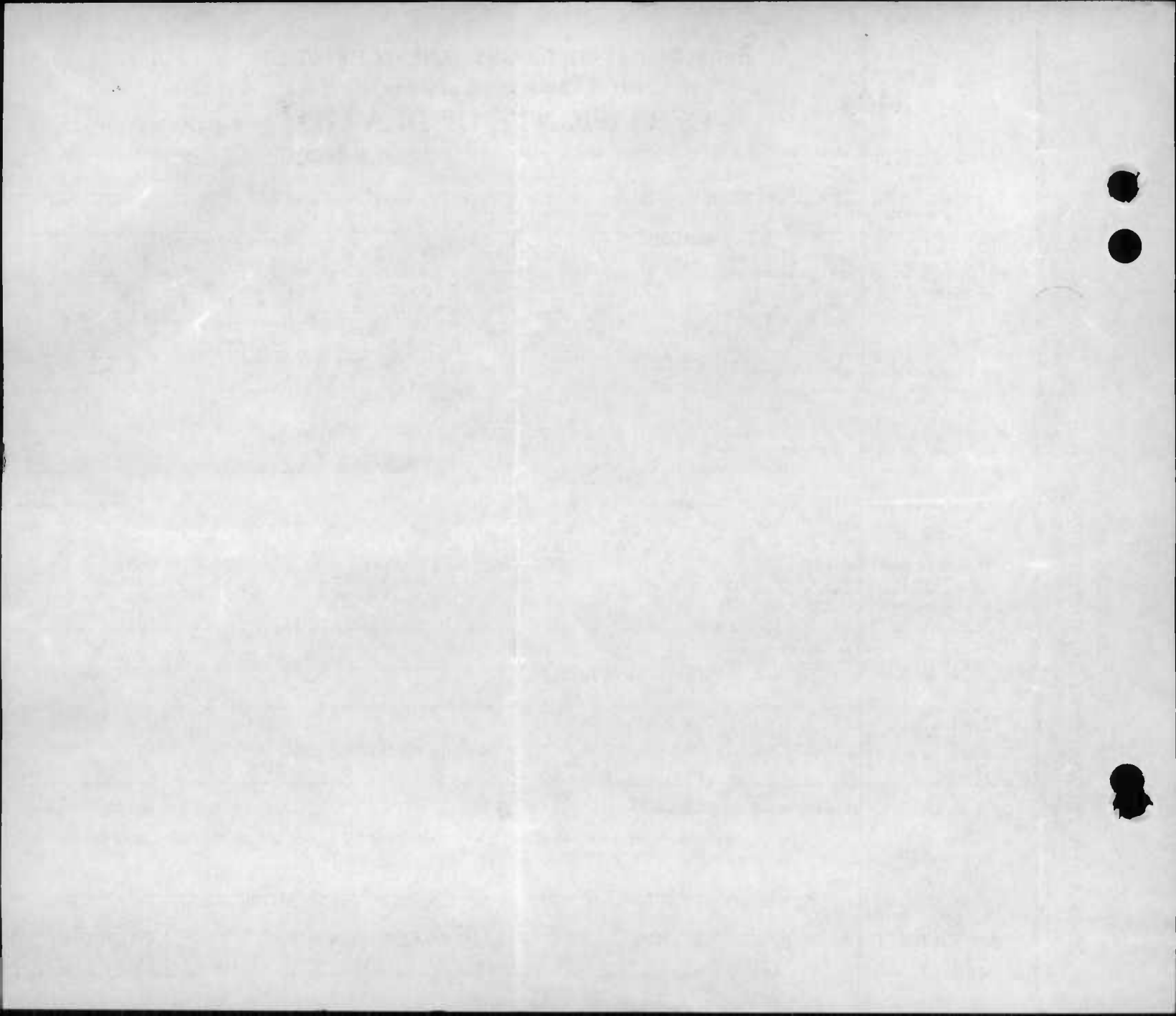
3424

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hanford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore County</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1812 Hanford Road</u>		STREET ADDRESS (If rural, give location) <u>1812 Hanford Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Edward</u> (First) <u>Adam</u> (Middle) <u>Himmelheber</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>8</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 6, 1880</u>
9. AGE last birthday <u>75</u> yrs.		10. If under 1 year Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Himmelheber</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Steinman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Wilhelmina Himmelheber - 1812 Hanford Rd</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>331X</u> Immediate cause (a) <u>Cerebral hemorrhage</u> Antecedent cause(s) (b) <u>Arteriosclerosis, cerebral</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 yr</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/26</u> , 19 <u>54</u> , to <u>8 Apr</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>55</u> , and that death occurred at <u>5:15 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Wm. A. Miller</u>		ADDRESS <u>1115 W. Miller Ave</u>	
DATE SIGNED <u>8 Apr 55</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 1, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		LOCATION (City, town, or county) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>John C. Miller Inc.</u>		ADDRESS <u>2431 E. Oliver St.</u>	
DATE REC'D BY LOCAL REG. <u>April 9 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	

MARGIN RESERVED FOR BINDING

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03400

Reg. Dist. No. 30

3425

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Westchester Ave.</u>		STREET ADDRESS (If rural, give location) <u>Westchester Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>BEULAH</u> (Middle) <u>ETHEL</u> (Last) <u>HIPSLEY</u>	4. DATE OF DEATH <u>4-4-55</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-18-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>70</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Pella, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles King</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Atkinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Richard J. Hipsley, Ellicott City, Md</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <u>Cerebral Arteriosclerosis</u>	<u>1 year</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>None</u>	
(c) <u>Arteriosclerotic Cardio-Vascular Disease</u>	<u>3 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>None</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 2, 1951, to April 4, 1955, that I last saw the deceased alive on April 2, 1955, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE William F. Zaccary (Degree or title) M.D. ADDRESS Ellicott City, Md DATE SIGNED 4/4/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-7-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	LOCATION (City, town, or county) <u>Baltimore, Md</u>	(State)
DATE REC'D. BY LOCAL REG. <u>4/6/55</u>	REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>	ADDRESS <u>Ellicott City, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 7 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03401

3426

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4150 Fallstaff Road</u>		STREET ADDRESS (If rural, give location) <u>4150 Fallstaff Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edgar</u>	(Middle) <u>Earl</u>	(Last) <u>Holmes</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>10</u>	(Year) <u>55</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/18/83</u>
9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Smelting Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel J. Holmes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Block</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>312-10-2082</u>	
17. INFORMANT AND ADDRESS <u>Mary B. Holmes, 4150 Fallstaff Rd.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>3 mos</u>
Antecedent cause(s) (b) <u>Coronary artery disease</u>		<u>Unknown</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 30, 1954, to Apr 9, 1955, that I last saw the deceased alive on Apr 9, 1955 and that death occurred at 2 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

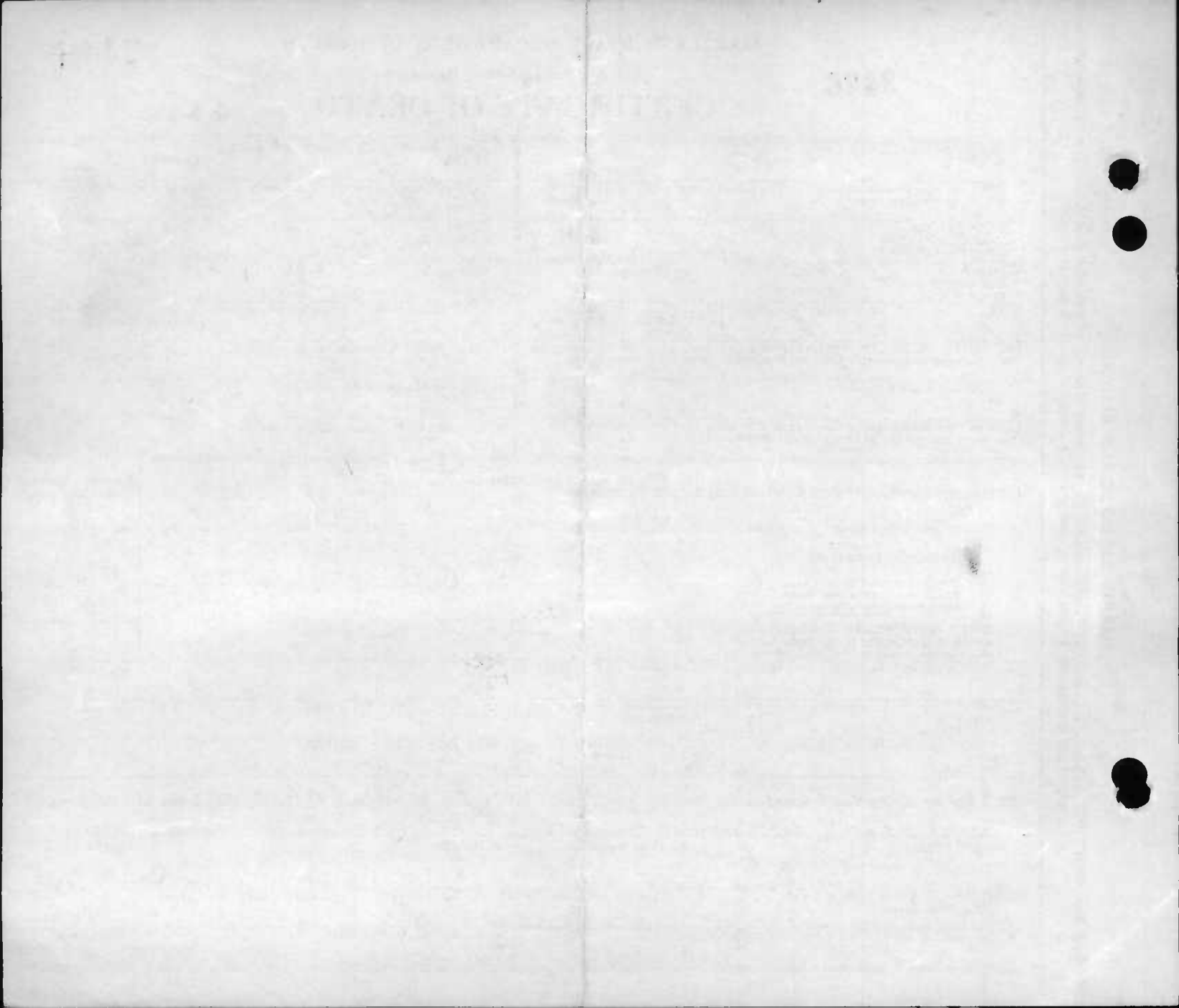
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 13/55</u>	<u>London Park</u>	<u>Balto.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/12/55</u>	<u>W. J. Hedlund</u>	<u>Loring Byers</u>	<u>5025 E. Falls Rd. Balto 15, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

03402

3427

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN WOODLAWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 3626 FOREST HILL ROAD		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN WOODLAWN STREET ADDRESS (If rural, give location) 3626 FOREST HILL ROAD	
3. NAME OF DECEASED (Type or Print) LOUISE	(First) M.	(Last) HOLMES	4. DATE OF DEATH (Month) (Day) (Year) APRIL 13 1955
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH March 27 1891
9. AGE last birthday 64 yrs.		10. If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD STAFF		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-10-3048	
17. INFORMANT AND ADDRESS Mrs. Edwin H. Reich, 3626 Forest Hill Road			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) 416X Cardiac De compensation Antecedent cause(s) (b) Rheumatic heart disease Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arthritis deformans		Unknown Many yrs 40

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4-10-55**, 19**55**, to **4-13-55**, 19**55**, that I last saw the deceased alive on **4-11-55**, 19**55**, and that death occurred at **4:30 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

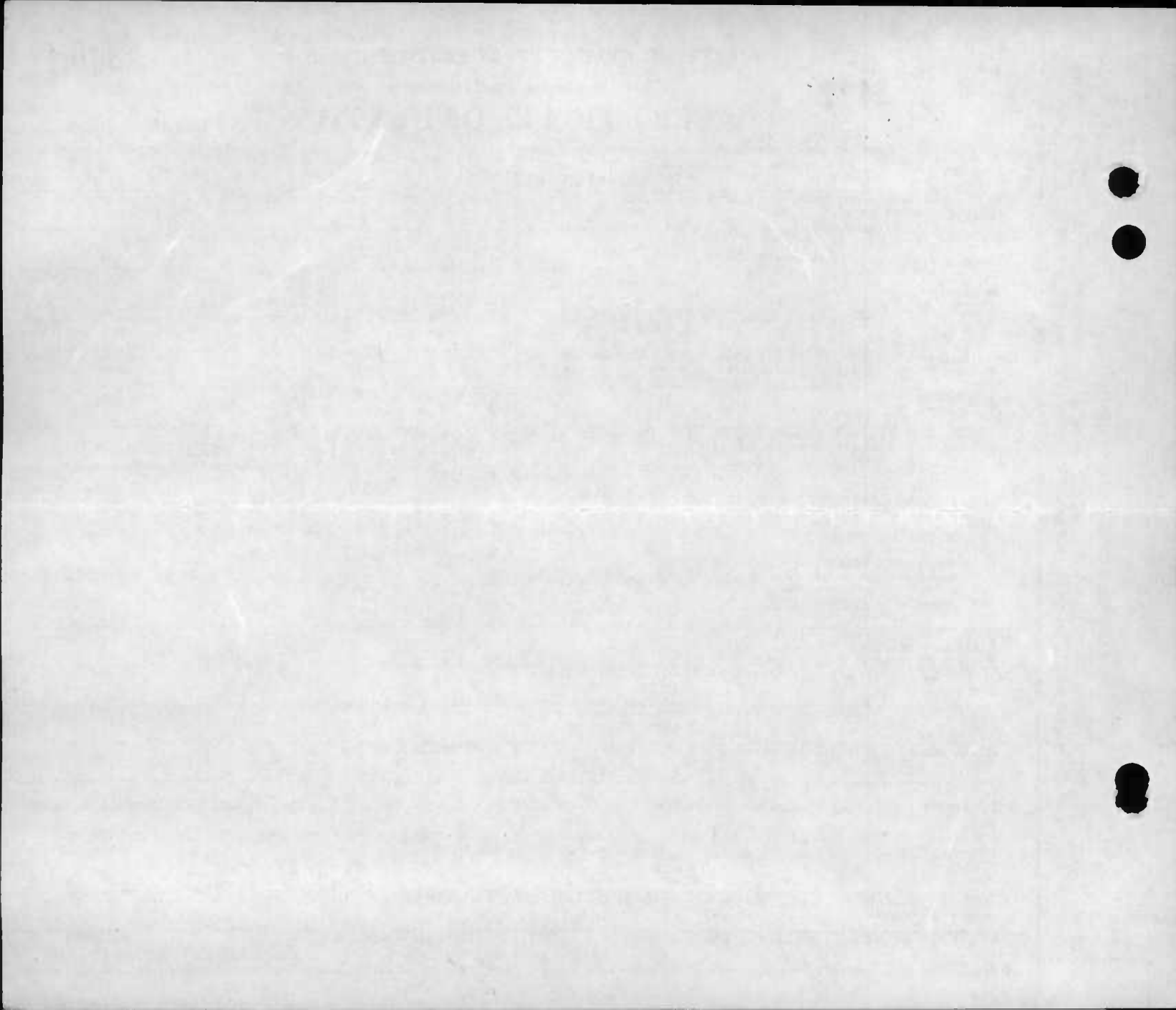
DATE SIGNED

E. B. Enzor M.D.**7201 York Rd Baltimore 12 Md**

23. BURIAL CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF April 15 1955	NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REG. 4-15-55	REGISTRAR'S SIGNATURE Edwin H. Reich	FUNERAL DIRECTOR Phillip Amos	ADDRESS 4510 Liberty Heights Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3428

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town)		OR TOWN	
55 Rural: Towson				Baltimore 12, Md.		3601-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Eudowood Sanatorium Towson 4, Maryland		STREET ADDRESS		(If rural give location)	
01				3004 White Ave.		✓	
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
ZELMA		L.		HUBERT		April 30, 19 55	
(Type or Print)							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		white		widowed		March 13, 1886	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
69 yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housewife						Harrisonburg, Va.	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
ALBERT CLARK				FLORENCE Leaveel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
No				—		Hospital Records - Eudowood Sanatorium	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				28 mo	
Immediate cause (a) DUE TO				Pulmonary Tuberculosis	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO					
(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?	
TIME (Month) (Day) (Year) (Hour) OF INJURY		m.			
22. I hereby certify that I attended the deceased from Feb 24, 19 53, to April 30 19 55, that I last saw the deceased alive on April 24, 19 55, and that death occurred at 8.00 A.M., from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		ADDRESS	
Milton B. Kress M.D.				Eudowood Sanatorium - Towson 4, Md.	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		5/3/55		Woodlawn Cem.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
5-2-55		A. W. [Signature]		Woodlawn, Md.	
				ADDRESS	
				Wm. J. Tichenor & Sons	
				Bldg 17 Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3429

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>38 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2404 E. Oliver Street</u>			
3. NAME OF DECEASED: (Type or Print) <u>JOHN</u>		(Middle) <u>W.</u>		(Last) <u>HUEBENTHAL</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 3, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>4/14/99</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Police Force</u>		11. BIRTHPLACE (State or foreign country): <u>San Francisco, California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Peter Huebenthal</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Schultz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give year or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>215-30-1920</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>MYOSARCOMA, RIGHT LUNG AND THORAX</u>						UNKNOWN	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BRONCHOPNEUMONIA, ARTERIOSCLEROTIC HEART DISEASE</u>							
19A. DATE OF OPERATION: <u>3/24/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>THORACOTOMY, RIGHT WITH EXCISION OF TISSUE FOR BIOPSY</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 24, 1955</u> , to <u>April 3, 1955</u> , that I last saw the deceased <u>at 5:50 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Abraham Polachek, M.D.</u> ADDRESS <u>M. D. FORT HOWARD, MARYLAND</u> DATE SIGNED <u>4/3/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-4-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>John C. Miller Inc. Funeral Home</u>		ADDRESS <u>2431 E. Oliver St., Baltimore 13, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE ASSISTANT SECRETARY FOR HOUSING

WASHINGTON, D.C. 20548

DATE: _____

TO: _____

FROM: _____

SUBJECT: _____

RE: _____

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3430

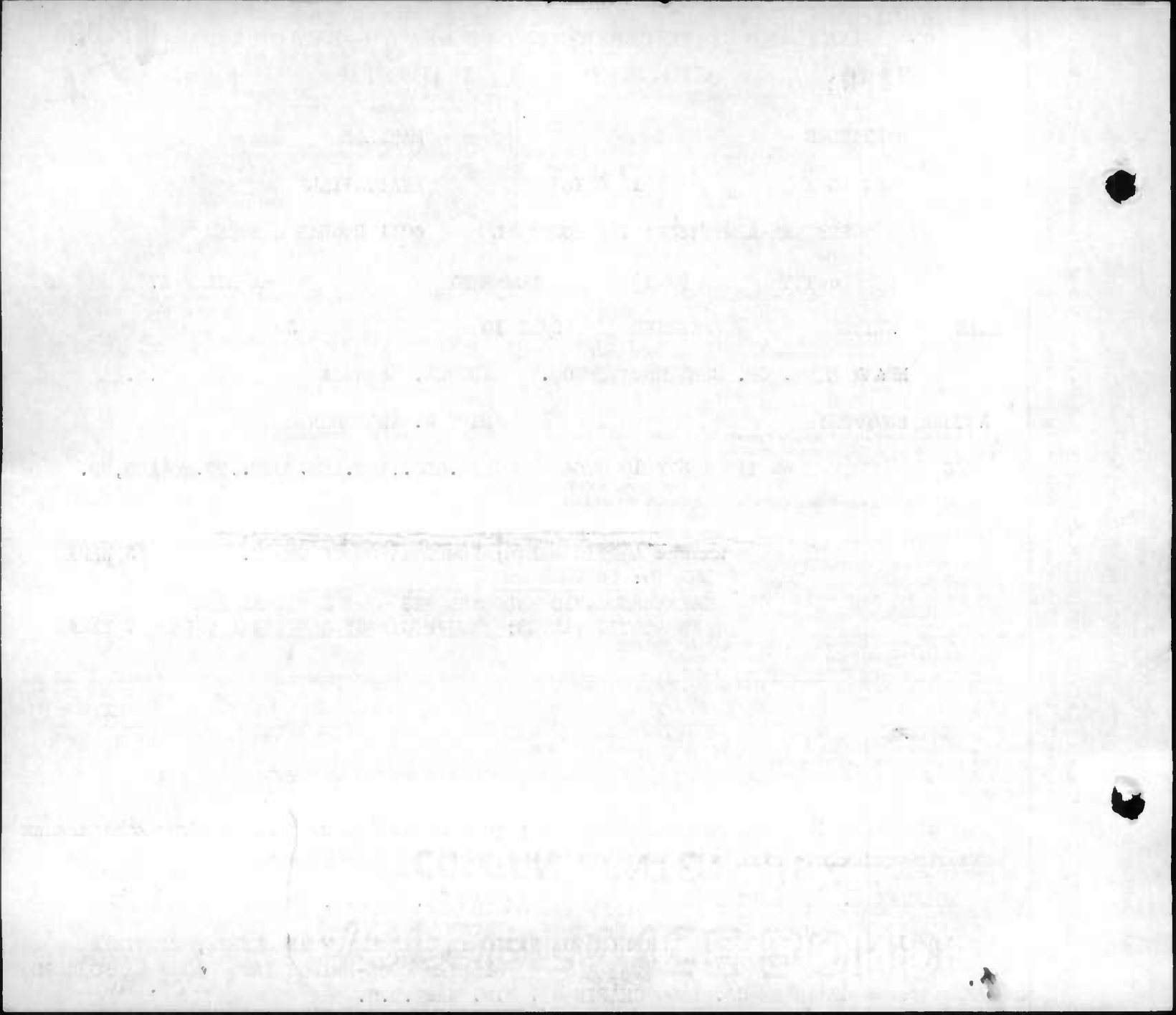
CERTIFICATE OF DEATH

Reg. Dist. No. 16-15-2

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY P. Va.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN FORT HOWARD		12 DAYS		TOWN HYATTSVILLE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
VETERANS ADMINISTRATION HOSPITAL				4011 BUCHANAN STREET			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DeWITT (NMI) HUMPHREY				DEATH: APRIL 27 19 55			
5. SEX: MALE		6. COLOR OR RACE: WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED		9. AGE last birthday 39 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HEAVY EQUIP. OP. CONSTRUCTION CO.				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): AUSTEL, GEORGIA	
13. FATHER'S NAME: ARTHUR HUMPHREY				14. MOTHER'S MAIDEN NAME: MARY E. ANDERSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): YES (If Yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 577 10 0764		17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) ULCERATIVE BACTERIAL ENDOCARDITIS OF THE AORTIC VALVE; PERFORATION OF CUSPS.						3 WEEKS	
ANTECEDENT CAUSE (S) DUE TO: UNKNOWN							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. RHEUMATIC ENDOCARDITIS OF THE MITRAL AND AORTIC VALVES; INSUFFICIENCY OF MITRAL VALVE						7 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from APRIL 15 1955 , to APRIL 27, 19 55 and that death occurred at 4:10 P.M. , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
WILLIAM B. VANDEGRIFT		M. D. VAH FT. HOWARD, MD		4/28/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
REMOVAL		APR. 29, 1955		ARLINGTON NATIONAL CEMETERY FORT MEYERS, VIRGINIA			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
29-51		WILLIAM COOK-BLIGHT INC		6009 HARFORD RD		BALTO. MD	
SHIPPED TO: WW CHAMBERS CO. 1400 CHAPIN ST. N.W. WASH. D.C.							

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

03406

3431

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3/

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>WOODLAWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2264 St Lukes Lane</u>		STREET ADDRESS (If rural, give location) <u>2264 St. Lukes Lane</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>EMMA</u> <u>L</u> <u>IMWOLD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> , <u>14th</u> , <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 29</u> 1871
9. AGE last birthday <u>83</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE GETTINGS</u>		14. MOTHER'S MAIDEN NAME <u>DORTHY ANN YEADAKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Thos. W. McConville 2264 St. Lukes Lane</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X Immediate cause

(a)

Carcinoma of colon

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

4 yearsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 12/25, 1945, to 4/14, 1955, that I last saw the deceased alive on 4/14, 1955, and that death occurred at 3.05 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

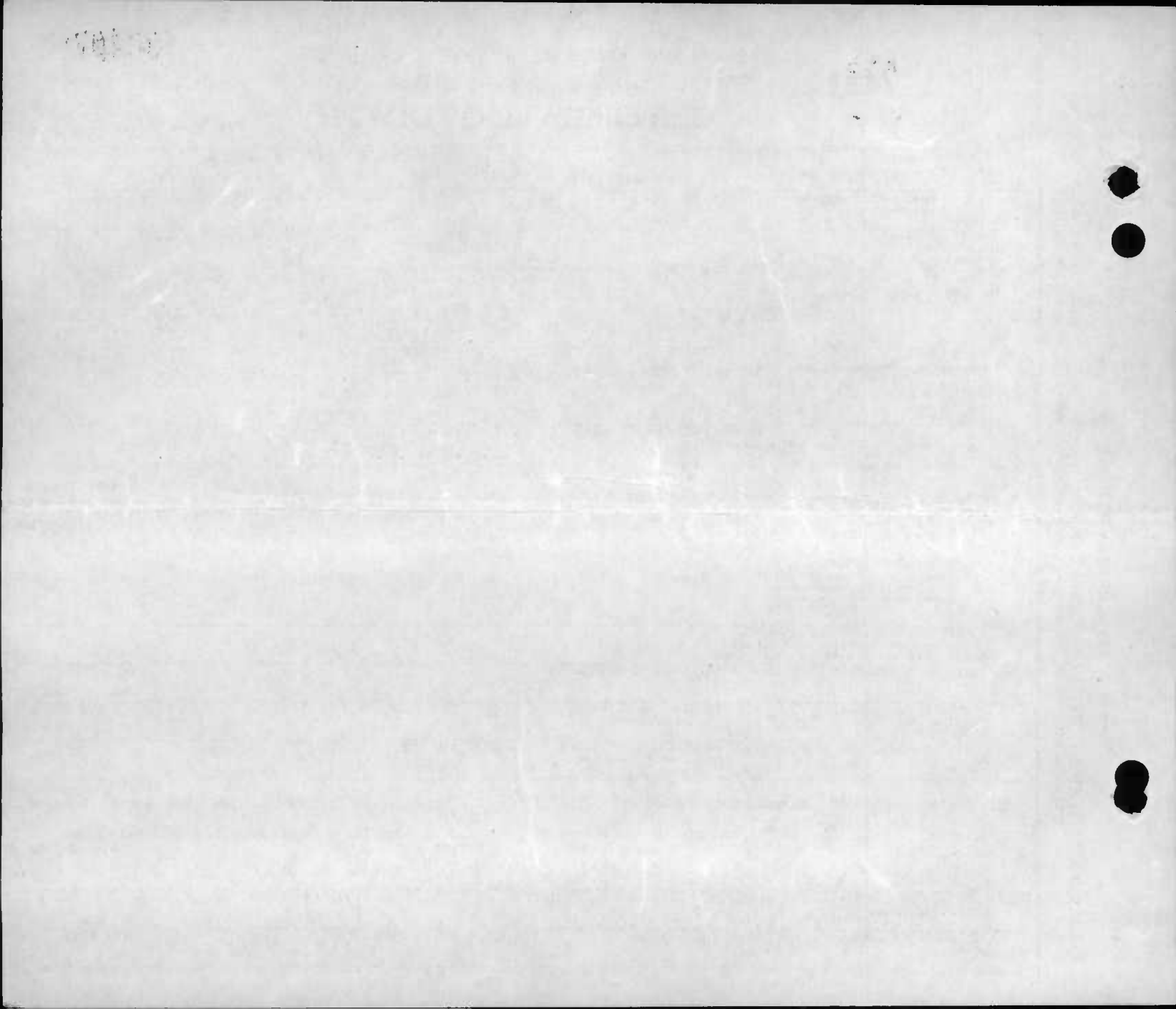
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 18</u> 1955	NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	LOCATION (City, town, or county) (State) <u>Balto Co Maryland</u>
DATE REC'D BY LOCAL REG. <u>4-18-55</u>	REGISTRAR'S SIGNATURE <u>W. A. Schmidt</u>	DE FUNERAL DIRECTOR <u>Miller Lawman</u>	ADDRESS <u>4510 Liberty Heights Ave.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3432

CERTIFICATE OF DEATH

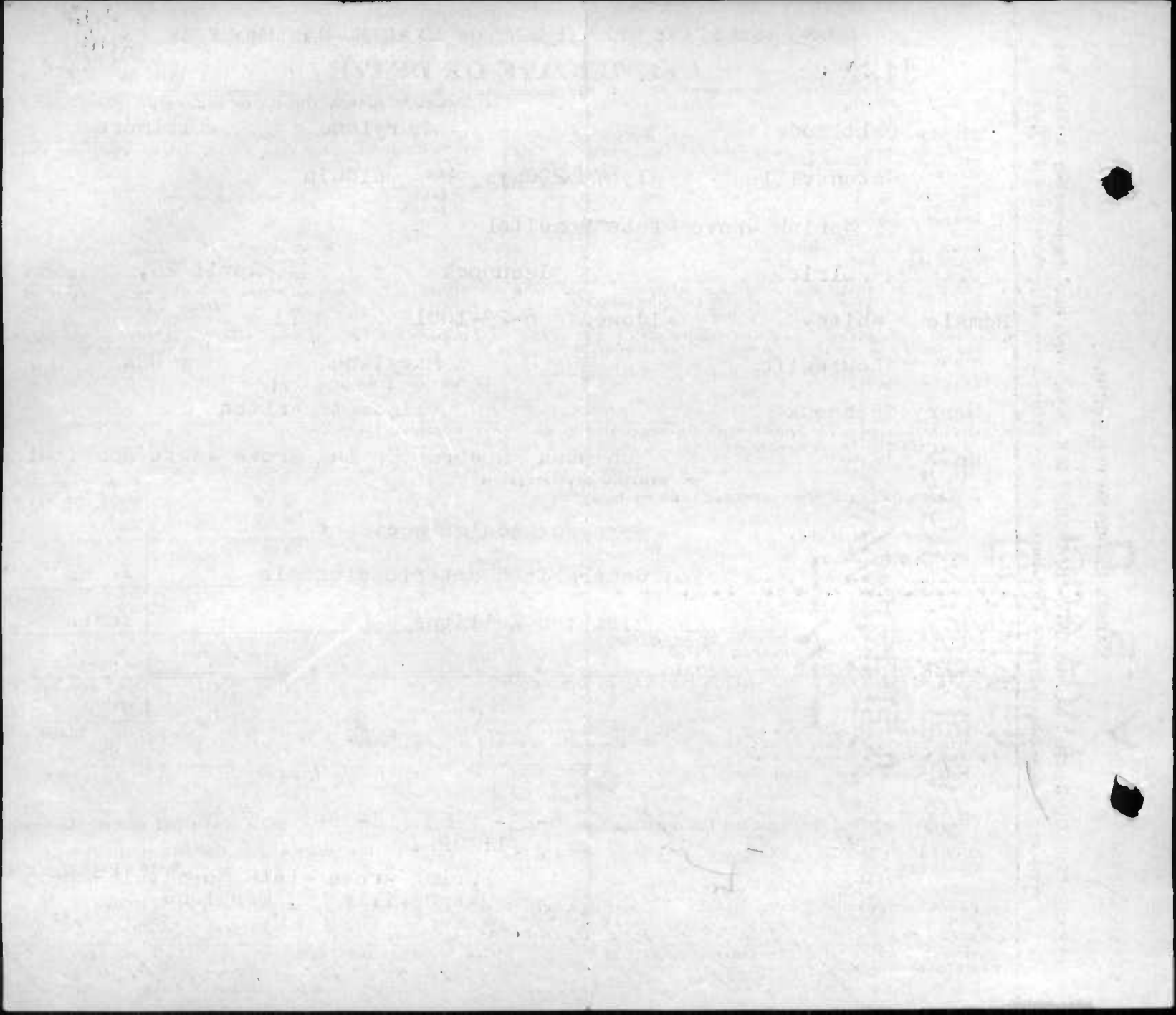
Reg. Dist. No. 03407

03407

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <u>Catonsville</u>		1yr7mo29days		OR TOWN <u>Baldwin</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
14 <u>Spring Grove State Hospital</u>				1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>Elsie Isennock</u>				OF DEATH <u>April 26, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Widowed	6-23-1881	73 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Henry Isennock</u>				<u>Elizabeth Walton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		Unknown		Records <u>Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>							
ANTECEDENT CAUSE (S) DUE TO						Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						Years	
(260X) (c) <u>Diabetes Mellitus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>8-23-</u> , <u>1953</u> , to <u>4-26-</u> , <u>1955</u> , that I last saw the deceased alive on <u>4-26-</u> , <u>1955</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE		<u>S. Wachler</u>		ADDRESS		DATE SIGNED	
				<u>Spring Grove State Hospital</u>		<u>4-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (C. U. town, or county) (State)	
<u>BURIAL</u>		<u>4/30/55</u>		<u>CHESTNUT GROVE PRESBYTERIAN Cem.</u>		<u>Chestnut Grove Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-29-55</u>		<u>Dr. H. H. H. H. H.</u>		<u>E. ARTHUR</u>		<u>Fork Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3433

CERTIFICATE OF DEATH

Reg. Dist. No. *KX*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL OR TOWN FORT HOWARD)	LENGTH OF STAY (in this place) 21 hrs. 50 min.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 1115 MADISON AVENUE	
3. NAME OF DECEASED: (Type or Print) EARLIE L. JAMES		4. DATE (Month) (Day) (Year) OF DEATH: April 23, 1955	
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 6-19-95
9. AGE last birthday 59 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor		10B. KIND OF BUSINESS OR INDUSTRY: Pipe Mill	
11. BIRTHPLACE (State or foreign country): Craddockville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Henry James		14. MOTHER'S MAIDEN NAME: Martha Sample	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW 1		16. SOCIAL SECURITY NO. 115-07-3915	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
421.1 IMMEDIATE CAUSE CALCIFIC DISEASE OF AORTIC VALVE WITH STENOSIS AND INSUFFICIENCY		10 years	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: April 23, 1955		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 23, 1955 , to April 23, 1955 , that I last saw the deceased alive on April 23, 1955 , and that death occurred at 10:50 AM , from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		ADDRESS VAH, Fort Howard, Md. DATE SIGNED 4/24/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-24-1955	
NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 25-53		REGISTRAR'S SIGNATURE H.W. Hedrick	
24. FUNERAL DIRECTOR Arlington S. Phillips Funeral Home		ADDRESS 1808 N. Monroe St. Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

101

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Manner of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of medical examiner		14. Signature of coroner		15. Signature of funeral director	
16. Signature of health officer		17. Signature of local health department		18. Signature of state health department		19. Signature of federal health department		20. Signature of other official	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

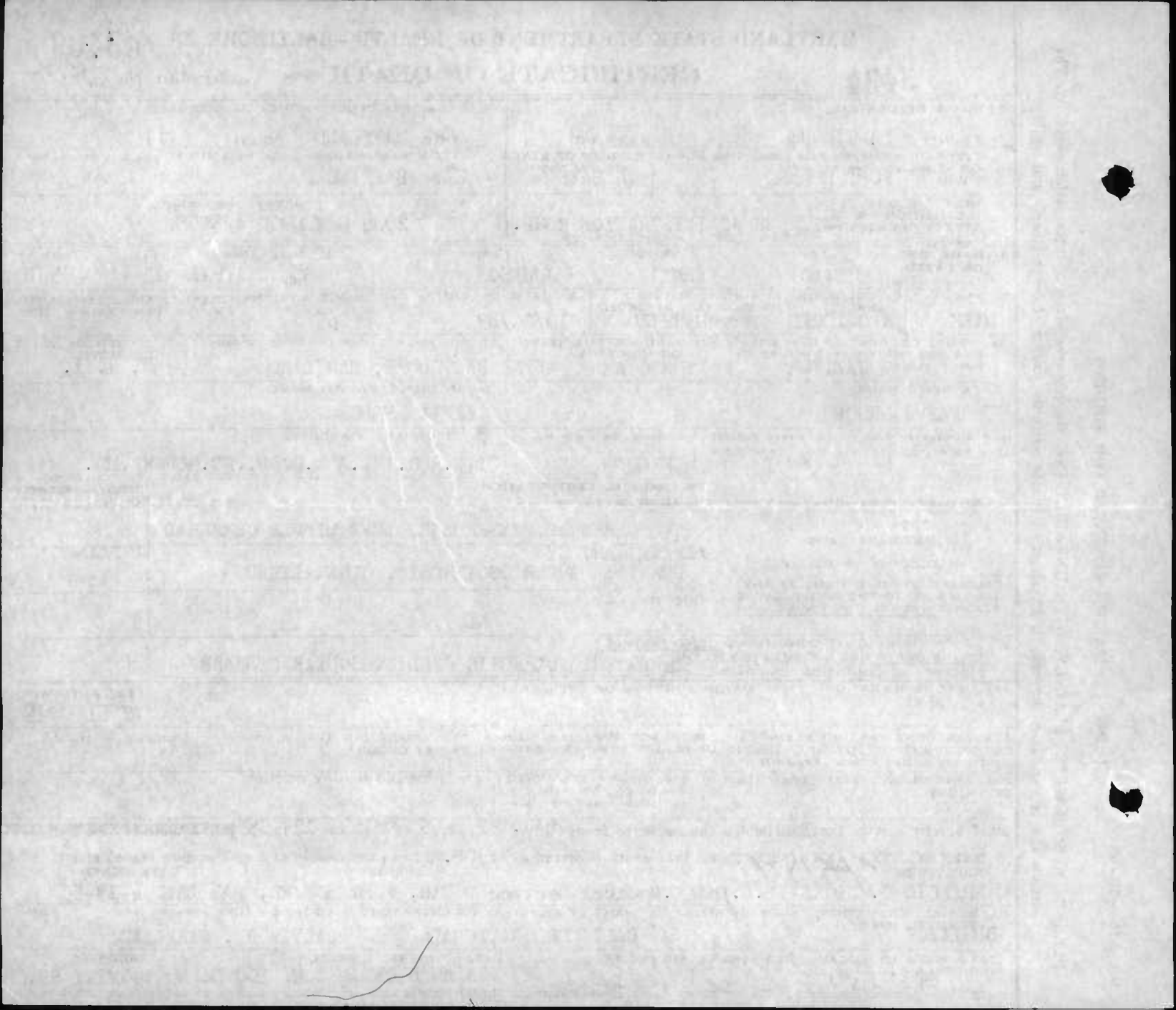
03409

Reg. Dist. No. *XX*

3434

CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town) FORT HOWARD	LENGTH OF STAY (in this place) 14 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSP.		STREET ADDRESS (If rural give location) 2004 HOMEWOOD AVENUE	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
ISAAC (NMI) JOHNSON		APRIL 12 1955	
5. SEX: MALE	6. COLOR OR RACE: COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: 10/20/89
9. AGE last birthday 65 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JANITOR		10B. KIND OF BUSINESS OR INDUSTRY: Y M C A	11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY: U. S. A.		13. FATHER'S NAME: THOMAS JOHNSON	
14. MOTHER'S MAIDEN NAME: OLIVIA SPENCE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) WW I	
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT & ADDRESS: CLIN.REC.VET.ADM.HOSP., FT.HOWARD, MD.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331X IMMEDIATE CAUSE CEREBRAL HEMORRHAGE, LEFT MIDDLE CEREBRAL ARTERY ANTECEDENT CAUSE (S) DUE TO: ARTERIOSCLEROSIS, GENERALIZED DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUPLICATE XA DUPLICATE (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from MAR. 29, 1955 , to APRIL 12, 1955 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.			
SIGNATURE Francis G. Dickey		DATE SIGNED	
FRANCIS G. DICKEY, M.D. Chief, Medical Service		ADDRESS VAH, FORT HOWARD, MARYLAND 4-13-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF April 18 55	
NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 4-15-55		REGISTRAR'S SIGNATURE H.W. Redner	
24. FUNERAL DIRECTOR ISAIAH BROWN, & SON		ADDRESS 108 W. MONTGOMERY ST. BALTIMORE, MD.	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2425
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03410

Reg. Dist.

No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u> MARYLAND	STATE <u>Md</u> COUNTY <u>Balto</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Edgemere</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Edgemere</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>26 Cottage Ave</u>		STREET ADDRESS (If rural, give location) <u>26 Cottage Ave</u>	
3. NAME OF DECEASED: (First) <u>Carolyn</u> (Middle) (Last) <u>Jones</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4-1-1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>9-27-51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>3</u> yrs.
		11. BIRTHPLACE (State or foreign country): <u>Balto, Md.</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Joseph K. Jones</u>		14. MOTHER'S MAIDEN NAME: <u>Gertrude Comer Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: <u>Gertrude C. Jones 256 Exeter St</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>42° Burns over entire body</u> Antecedent cause(s) (b) <u>None</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>NO</u>		19b. MAJOR FINDING OF OPERATION: <u>NO</u>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	21c. (City or town) <u>Dundalk, Balto.</u> (County) <u>Md.</u> (State)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-1-55 12 P. M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Car into burning house</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>John J. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/2/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> M. D.	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>4/2/55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
DATE REC'D BY LOCAL REG. <u>April 4-55</u>	REGISTRAR'S SIGNATURE <u>Dawson L. Harbor</u>	24. FUNERAL DIRECTOR <u>Charles K. Law 808 Madison Ave</u> ADDRESS	

RECEIVED

APR 11 1955

BUREAU V. S.

3333

03411
Reg. Dist.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Lansdowne</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Lansdowne</u>	51
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>224 Hazel ave</u>		STREET ADDRESS (If rural, give location) <u>224 Hazel ave</u>	
3. NAME OF DECEASED: (Type or Print) <u>Mrdecai Lem Kastner</u>		4. DATE OF DEATH <u>April 15</u> 19 <u>35</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 3 1889</u>
9. AGE last birthday: <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired) <u>Retired collector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME: <u>Nathan L Kastner</u>		14. MOTHER'S MAIDEN NAME: <u>Leibman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>215 07 0636</u>	
17. INFORMANT & ADDRESS: <u>Lem A Kastner 4901 Stafford Rd Balt 2</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
4221 Immediate cause (a) <u>Acute Cardiac failure</u> DUE TO		
Antecedent cause(s) (b) <u>Bronchial asthma</u> Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last (c) <u>Cardiovascular disease.</u> DUE TO		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Dr. M. Kieffer</u>		1010 Reedon CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. <u>April 25 35</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>4-27-35</u>	NAME OF CEMETERY OR CREMATORY: <u>Hebrew Friendship Cem</u>	LOCATION (City, town, or county) (State): <u>Balto md</u>
DATE REC'D BY LOCAL REG. <u>4/26/35</u>	REGISTRAR'S SIGNATURE: <u>Dr. W. Hedgcock</u>	24. FUNERAL DIRECTOR: <u>Mr. Cook Inc. 1217 St Paul St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1452a
Sgt. Kelle

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03412

3436

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Ca Lonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove St. Hospital</u>				STREET ADDRESS (If rural give location) <u>1720 Harden Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Rose Kaufman</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>4</u> <u>5</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>2-7-1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Abraham</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Kirschenbaum</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>							<u>5 days</u>
ANTECEDENT CAUSE (S) DUE TO <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>54</u> , to <u>4/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/5</u> , 19 <u>55</u> , and that death occurred at <u>4:35 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. Wachler</u>		ADDRESS <u>Spring Grove St. Hospital</u>		DATE SIGNED <u>4/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/5/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		24. FUNERAL DIRECTOR <u>Jack Lewis</u>		ADDRESS <u>2100 Eutaw Pl</u>	

BUREAU V. S.

APR 7 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03413

3437 CERTIFICATE OF DEATH

Reg. Dist. No. 457

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> TOWN <u>Fort Howard</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>6212 Shipview Way</u>	
3. NAME OF DECEASED: (Type or Print) <u>RALPH J. KELLAM</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 3, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>2/6/94</u>
9. AGE last birthday <u>61</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.		10. BIRTHPLACE (State or foreign country): <u>Onancock, Virginia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Tank Kellam</u>		14. MOTHER'S MAIDEN NAME: <u>Bertie Pennywell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>213-12-2200</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>163X</u> IMMEDIATE CAUSE (A) <u>CARCINOMA OF THE LUNG, RIGHT</u> ANTECEDENT CAUSE (S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21A. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21B. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21C. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21D. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21E. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 28, 1955</u> , to <u>April 3, 1955</u> , that I last saw the deceased <u>alive on</u> <u>March 28, 1955</u> , and that death occurred at <u>8:55A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>William B. VandeGrift, M.D.</u>		ADDRESS <u>M. D. Fort Howard, Maryland</u> DATE SIGNED <u>4/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>APR. 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore, National</u> LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-6-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Blight Inc.</u>		ADDRESS <u>6009 Harford Rd. Baltimore, Md.</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

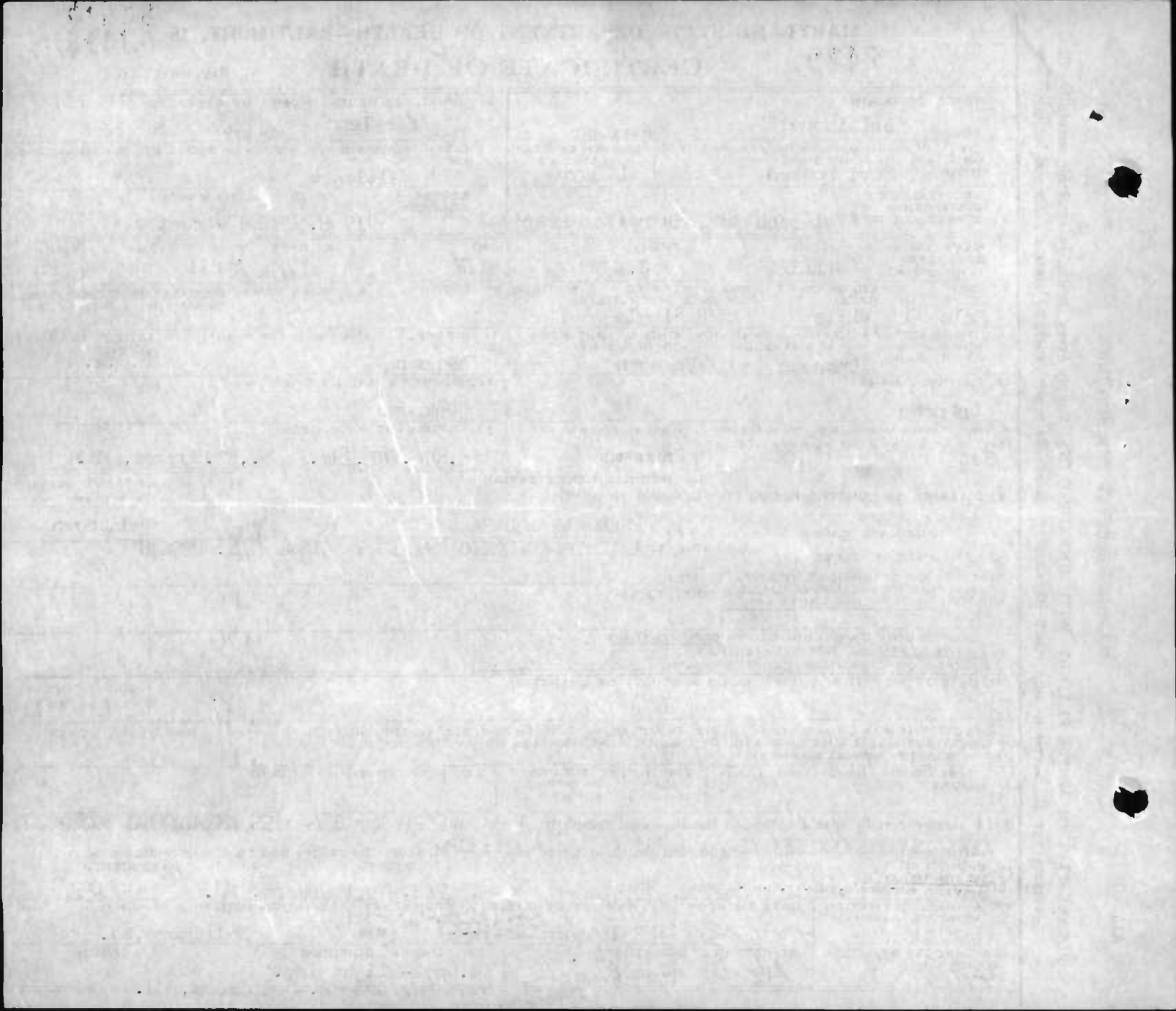
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3438 CERTIFICATE OF DEATH

03414

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Fort Howard		LENGTH OF STAY (in this place) 4 Days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 919 E. Chase Street			
3. NAME OF DECEASED: (First) (Middle) (Last) WILLIAM J. KELLY				4. DATE (Month) (Day) (Year) OF DEATH: April 6 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single		8. DATE OF BIRTH:	
9. AGE last birthday 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown		10b. KIND OF BUSINESS OR INDUSTRY: Unknown		11. BIRTHPLACE (State or foreign country): Unknown	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) PULMONARY EDEMA ANTECEDENT CAUSE (S) DUE TO ARTERIOSCLEROTIC CARDIO VASCULAR DIS. DECOMP						INTERVAL BETWEEN ONSET AND DEATH Unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 2, 1955 , to April 6, 1955 , and that death occurred at 11:30 PM , from the causes and on the date stated above. GIVEN ON April 6, 1955 , and that death occurred at 11:30 PM , from the causes and on the date stated above. SIGNATURE Irving Freeman, M.D. ADDRESS VAH, Fort Howard, Md. DATE SIGNED 4/8/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF APRIL 12, 1955		NAME OF CEMETERY OR CREMATORY St. Peter's National Cem.		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 4/11/55		REGISTRAR'S SIGNATURE Dr. Hediger		24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Blight Inc. 6009 Harford Rd. Baltimore, Md.			



03415

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3439
CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cheverly</u> <u>16-38-2</u>			
52 TOWN <u>Catonsville</u>		9 days		STREET ADDRESS (If rural give location) <u>Unknown</u> ✓			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 30, 19 55</u>			
<u>Cora King</u>							
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Unknown</u>	<u>83?</u> yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>				<u>Unknown</u>		<u>Unknown</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>Unknown</u>		<u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u> Years							
ANTECEDENT CAUSE (S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-21-</u> , 19 <u>55</u> to <u>4-30-</u> , 19 <u>55</u> that I last saw the deceased alive on <u>4-30-</u> , 19 <u>55</u> , and that death occurred at <u>8:50AM.</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Wachler</u>		ADDRESS <u>Spring Grove State Hospital</u>		DATE SIGNED <u>4-30-55</u>			
23. BURIAL, CREMATION, REMOVAL (specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>May 5-1955</u>		<u>old St Pauls</u>		<u>Baltimore</u>		<u>Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-4-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR		ADDRESS	
				<u>Wm Conk Inc-1217 St Paul St</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3440

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03416

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Catonsville	COUNTY	Baltimore
LENGTH OF STAY (in this place)	1mo. 25 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Sparrows Point
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Spring Grove State Hospital	STREET ADDRESS (If rural give location)	720 "F" Street
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
ALICE J. KRAMER		April 5, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Female	White	Widowed	12-8-1876
9. AGE last birthday		IF UNDER 1 YEAR	
78 yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
Housewife			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Richard J. JAMES.		Mary V. McFall McFAUL.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		220-14-5885	
17. INFORMANT & ADDRESS:		Records Spring Grove State Hospital	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE (A) Cerebrovascular accident			
ANTECEDENT CAUSE (B) Arteriosclerotic cardiovascular disease Years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-11-, 1955 to 4-5-, 1955, that I last saw the deceased alive on 4-5-, 1955, and that death occurred at 7 A M, from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
J. E. Kramers		M. D. Spring Grove	
DATE SIGNED		4-5-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		Catholics + Lutheran	
LOCATION (City, town, or county) (State)		Baltimore	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
4-6-55		A. W. O. Glick	
REGISTRAR'S SIGNATURE		ADDRESS	
		108 W. York St.	

STATEMENT OF DEBTS

NAME OF DEBTOR	AMOUNT	DATE
J. A. Smith	100.00	1/1/1912
W. B. Jones	50.00	2/1/1912
C. D. Brown	75.00	3/1/1912
E. F. White	25.00	4/1/1912
G. H. Black	150.00	5/1/1912
I. K. Green	30.00	6/1/1912
L. M. Hall	40.00	7/1/1912
N. O. Young	60.00	8/1/1912
P. Q. Reed	80.00	9/1/1912
R. S. Cook	90.00	10/1/1912
T. U. Bailey	110.00	11/1/1912
V. W. Fisher	120.00	12/1/1912
X. Y. Grant	130.00	1/1/1913
Z. A. King	140.00	2/1/1913
B. C. Lee	150.00	3/1/1913
D. E. Miller	160.00	4/1/1913
F. G. Wilson	170.00	5/1/1913
H. I. Moore	180.00	6/1/1913
J. K. Taylor	190.00	7/1/1913
L. M. Evans	200.00	8/1/1913
N. O. Roberts	210.00	9/1/1913
P. Q. Walker	220.00	10/1/1913
R. S. Hall	230.00	11/1/1913
T. U. King	240.00	12/1/1913
V. W. Lee	250.00	1/1/1914
X. Y. Miller	260.00	2/1/1914
Z. A. Moore	270.00	3/1/1914
B. C. Taylor	280.00	4/1/1914
D. E. Evans	290.00	5/1/1914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balts</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>UPPER MERIDEN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ACADEMIA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>UPPER MERIDEN</u>		STREET ADDRESS <u>UPPER MERIDEN</u>	
3. NAME OF DECEASED (Type or Print) <u>L - HAZEL - A - LAMOTTE</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>24</u> (Year) <u>1955</u>	
5. SEX <u>OH</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-25-1885</u>
9. AGE last birthday <u>70</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles H. Lapp</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Ashe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>138-26-9678</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Adelaide Zeff - Upper Meriden</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
181X Immediate cause (a) <u>Pseudo-Nephritis</u>		<u>2 mo.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <u>Carcinoma of Bladder</u>	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>May 1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Bladder</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 34</u> , 19 <u>54</u> , to <u>April 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 23</u> , 19 <u>55</u> , and that death occurred at <u>6:15a</u> m., from the causes and on the date stated above.			
SIGNATURE <u>M.C. Carterfield, M.D.</u>		ADDRESS <u>Hamstead Md</u>	
DATE SIGNED <u>4/24/55</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Apr 27/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		LOCATION (City, town, or county) (State) <u>Balts Co Md</u>	
24. FUNERAL DIRECTOR <u>Edw Chilton, Hamstead Md</u>			
25. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>			
DATE REC'D BY LOCAL REG. <u>4-26-55</u>			

RECEIVED
MAY 3 1965
BUREAU V. 3

CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 7, Film 181 5-23-55 et

1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK (22) LENGTH OF STAY (in this place) 40 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3601 NORTH POINT BLVD.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY BALTO.
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22, MD
STREET ADDRESS (If rural give location) 3601 NORTH POINT BLVD.

3. NAME OF DECEASED:

(First) HENRY (Middle) (NM) (Last) HAUBACH

4. DATE OF DEATH: (Month) 4 (Day) 24 (Year) 1955

5. SEX:

MALE

6. COLOR OR RACE:

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH:

JAN 10, 1887

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: STOCK FARM

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

CHRISTIAN

LAUBACH

14. MOTHER'S MAIDEN NAME:

MARY

(UNK)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 218-32-4196

17. INFORMANT & ADDRESS: ELIZABETH MILLER - SAME ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a) DUE TO

Coronary Thrombosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

Coronary arteriosclerosis

(c)

Interval Between Onset And Death

Immediate

2 years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1953 to 21 April, 1955, that I last saw the deceased alive on 21 April, 1955, and that death occurred at 7:30 AM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIAL

4-27-55

OAK LAWN

BALTO. Co., MD.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 26-1955 William M Kelly Walt Burke Bodley, Dundalk, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 28 1955

BUREAU V. S.

3442

03419

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. *42*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>Pa.</i>	COUNTY <i>Lancaster</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Sutton</i>	LENGTH OF STAY (in this place) <i>Visiting</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Lancaster</i>	<i>83X-3</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3613 Putty Hill Rd.</i>		STREET ADDRESS (If rural, give location) <i>Rt # 2</i>	
3. NAME OF DECEASED: (Type or Print) <i>Claude Milnot Lester Sr.</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>April 11 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>Sept 22/1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Bar Keeper</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Cashier</i>	9. AGE last birthday: <i>73</i> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME: <i>Amanda</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>227-10-5339</i>	
		17. INFORMANT & ADDRESS: <i>MRS W. WANN 3613 PUTTY HILL RD.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		<i>Immediate Autopsy</i>
Immediate cause (a) <i>Coronary occlusion</i>	DUE TO	
Antecedent cause(s) (b) <i>Cardiovascular disease</i>	DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF <i>April 11 1955 8:00 A.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE *M. D. M. D.* M. D. *ASSIGNING MEDICAL EXAMINER* DATE SIGNED *APR 11 1955*

23. BURIAL, CREMATION, REMOVAL (Specify): <i>BURIAL</i>	DATE THEREOF: <i>APRIL 14 1955</i>	NAME OF CEMETERY OR CREMATORY: <i>WOOD LAWN</i>	LOCATION (City, town, or county) (State): <i>Bluefield WV</i>
DATE REC'D BY LOCAL REG. <i>4-11-55</i>	REGISTRAR'S SIGNATURE: <i>W. D. Hedgcock</i>	24. FUNERAL DIRECTOR: <i>CHAS F FERNANDES & SON 8802 HARTFORD RD.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNIVERSITY OF CHICAGO
LIBRARY

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "University" and "Library" are faintly visible.]

03420

MARYLAND

STATE DEPARTMENT OF HEALTH

3443

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Reisterstown Road</u>		STREET ADDRESS (If rural, give location) <u>Reisterstown Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>JESSE</u> (Middle) <u>LEE</u> (Last) <u>Logsdon</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>14</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>JAN. 26, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clockmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Logsdon</u>		14. MOTHER'S MAIDEN NAME <u>Laura Cole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>218-10-0910</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Gene Logsdon, Reisterstown Rd.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 Immediate cause		(a) <u>Cardiac failure</u>	
Antecedent cause(s)		(b) <u>Coronary Insufficiency</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>Congestive Heart Failure - Chronic</u>	
II. OTHER SIGNIFICANT CONDITIONS		Interval between Onset and Death	
Conditions contributing to the death but not related to the disease or condition causing death.		5 min.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>54</u> , to <u>April 14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>55</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Charles E. McWilliams</u> (Degree or title)		ADDRESS <u>Reisterstown Maryland</u>	
DATE SIGNED <u>April 14/1955</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Stones Chapel</u>	
DATE REC'D BY LOCAL REG. <u>4-14-55</u>		LOCATION (City, town or county) <u>Pikesville Md.</u>	
REGISTRAR'S SIGNATURE <u>Mary E. Eline</u>		24. FUNERAL DIRECTOR <u>Ann Berryman & Sons</u>	
		ADDRESS <u>Reisterstown</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR 18 1955

RECEIVED

APR 18 1955

RECEIVED

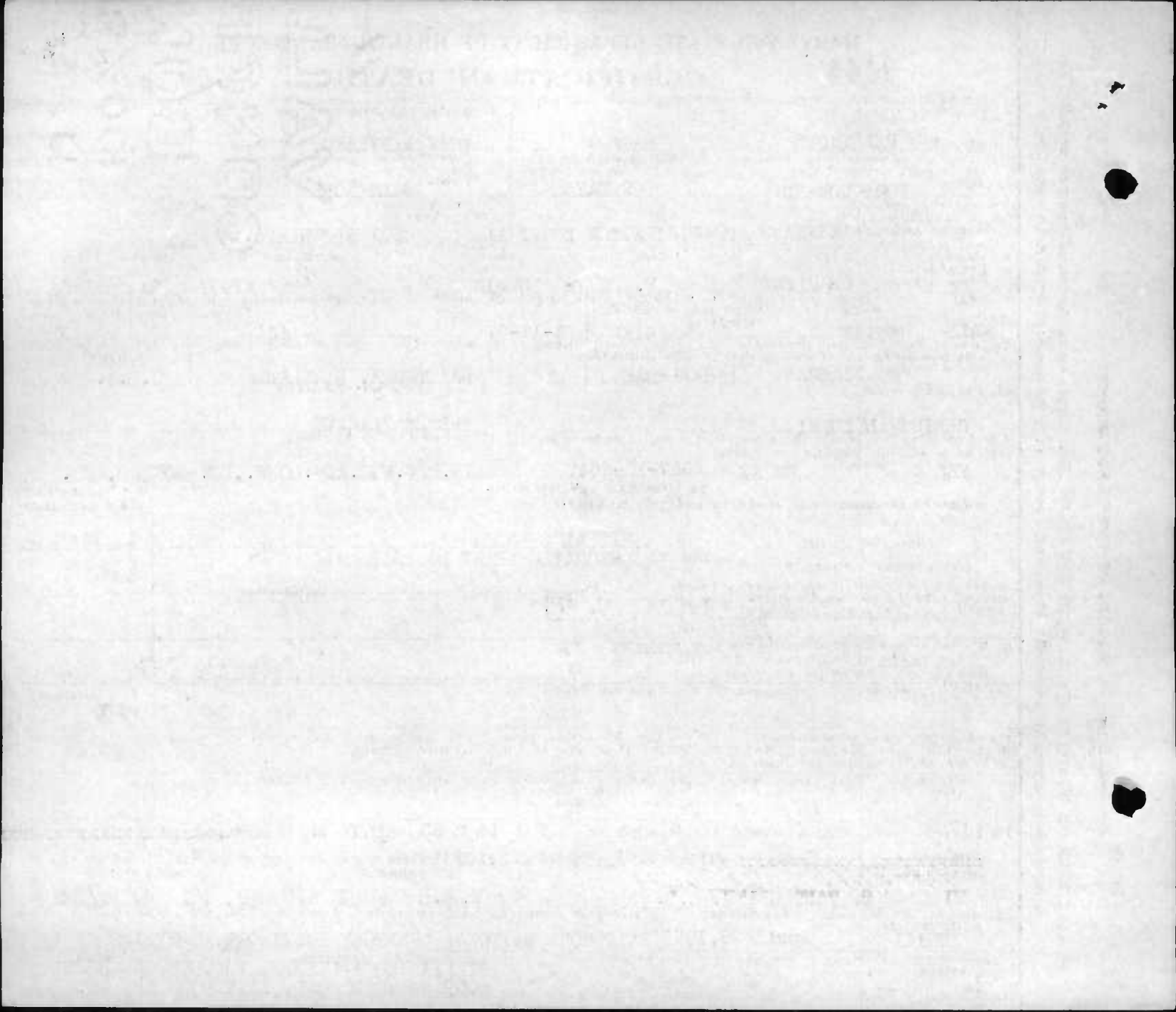
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3444 CERTIFICATE OF DEATH

03421

Reg. Dist. No. 4X

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>FORT HOWARD</u>		LENGTH OF STAY (in this place) <u>9 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>6301 BROWN AVE.</u>					
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES E. LUDWIG</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 23 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>4-17-07</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FIREMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>CHRISTIAN LUDWIG</u>				14. MOTHER'S MAIDEN NAME: <u>THERESA LACKEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES WW II</u>		16. SOCIAL SECURITY NO. <u>907-10-9647</u>		17. INFORMANT & ADDRESS: <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>MITRAL STENOSIS</u>						12 Years	
DUE TO <u>RHEUMATIC HEART DISEASE</u>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>X</u> attended the deceased from <u>APRIL 14, 1955</u> to <u>APRIL 23, 1955</u> and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>WILLIAM B. VANDEGRIFT, M.D.</u>				DATE SIGNED <u>4/24/55</u>			
ADDRESS <u>M.D. V.A.H. FORT HOWARD, MD</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>April 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-21</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>WILLIAM COOK-BLIGHT, INC. FUNERAL HOME 6009 HARFORD ROAD, BALTIMORE 14, MD.</u>			



3445

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

COUNTY Baltimore MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) Baldwin LENGTH OF STAY (in this place) 68 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md COUNTY BaltimoreCITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baldwin Rd.

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First) John (Middle) Francis (Last) Synch

(Type or Print)

4. DATE (Month) (Day) (Year)

OF DEATH: Apr 2 1955

5. SEX:

m

6. COLOR OR RACE:

w7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH:

Sept 59. AGE last birthday: 68 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer10B. KIND OF BUSINESS OR INDUSTRY: General Farming11. BIRTHPLACE (State or foreign country): Baldwin Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Michael Henry Synch

14. MOTHER'S MAIDEN NAME:

Ella Teresa Kelly15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes16. SOCIAL SECURITY NO. 201-1-10000

17. INFORMANT & ADDRESS:

Edward X Synch Baldwin

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) DUE TO

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1930, to April 2, 1955 that I last saw the deceased alive on 2/2, 1955, and that death occurred at 6:30 M, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

APR 11 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3446 CERTIFICATE OF DEATH

03428

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (if outside corporate limits, write RURAL OR and give nearest town) <u>52 TOWN Catonsville</u>	LENGTH OF STAY (in this place) <u>1 yr 10 mos 16 days</u>	CITY (if outside corporate limits, write RURAL and give nearest town) <u>TOWN Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		STREET ADDRESS (if rural give location) <u>7514 Brightside Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Emerson Vernon Marchant</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 6, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>10-4-1904</u>
9. AGE last birthday <u>50</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Paint</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>R. B. Marchant</u>		14. MOTHER'S MAIDEN NAME: <u>Grace Scarborough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown World War II</u>		16. SOCIAL SECURITY NO. <u>212-16-6576</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute coronary thrombosis</u>		<u>Hours</u>	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchopneumonia</u>		<u>2 days</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-21-</u> , 19 <u>53</u> to <u>4-6-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-6-</u> , 19 <u>55</u> , and that death occurred at <u>9:00 AM</u> from the causes and on the date stated above.			
SIGNATURE <u>Spring Grove State Hospital</u>		DATE SIGNED <u>4/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>4/8/55</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore Natl.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/17/55</u>	REGISTRAR'S SIGNATURE <u>H. E. Harry</u>	24. FUNERAL DIRECTOR <u>Larsen Funeral Home 7401 Belair</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RD

RECEIVED
FBI
APR 19 1955

RECEIVED
APR 19 1955
BUREAU V. 2

3447

CERTIFICATE OF DEATH

1. PLACE OF DEATH: 606 MILD FORD MILL ROAD		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTIMORE COUNTY</u>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Pikesville</u>	LENGTH OF STAY (in this place) <u>32 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>P. Kesville</u> <u>8</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>606 Mild Ford Mill Road</u>	
3. NAME OF DECEASED: (First) <u>Joseph</u> (Middle) <u>GIBBONS</u> (Last) <u>MATHER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>APR 11</u> <u>2</u> <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>NOV. 11, 1883</u>
9. AGE last birthday: <u>72</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	11. BIRTHPLACE (State or foreign country): <u>BALTIMORE MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>		13. FATHER'S NAME: <u>WILLIAM MATHER</u>	
14. MOTHER'S MAIDEN NAME: <u>MARY MCCULLOUGH</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): <u>NO</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.: <u>212-10-7571A</u>		17. INFORMANT & ADDRESS: <u>same address</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
410X IMMEDIATE CAUSE (A) <u>Pneumonia</u>			<u>48 hrs</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Maternal insufficiency</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arterio-sclerotic heart disease</u>			<u>20 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic bronchitis, Pulmonary emphysema</u>			
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>fall</u> , 19 <u>45</u> , to <u>4/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/1</u> , 19 <u>55</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Rene D. Salzman</u>		DATE SIGNED <u>4/7/55</u>	
ADDRESS <u>M.D. 1413 Peabody tower Rd.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-5-55</u>	
NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		LOCATION (City, town, or county) (State) <u>WOODLAWN MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>APR 11 4/11/55</u>		REGISTRAR'S SIGNATURE <u>Harold A. Newell</u>	
24. FUNERAL DIRECTOR <u>FRANK H. NEWELL</u>		ADDRESS <u>Pikesville MD</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

APR 6 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03425
3448 CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>	LENGTH OF STAY (in this place) <u>62 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Carmel Rd.</u>		STREET ADDRESS (If rural give location) <u>Mt. Carmel Rd.</u>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Blaine</u>	(Middle)	(Last) <u>Mays</u>	(Month) <u>April</u> (Day) <u>20</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>December 4/1886</u>
9. AGE last birthday: <u>68</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <u>Farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. BIRTHPLACE (State or foreign country): <u>Baltimore Co., Md.</u>	
14. FATHER'S NAME: <u>Robert H. Mays</u>		15. MOTHER'S MAIDEN NAME: <u>Carrie A. Thompson</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		17. SOCIAL SECURITY No.: <u>—</u>	
18. INFORMANT & ADDRESS: <u>Mrs. Stanley Thompson - Parkton, Md. R.D.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
422.1 Immediate cause (a) <u>Coronary Heart Failure</u>		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arterio-sclerotic C.V. Disease</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		12. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
13a. DATE OF OPERATION: 13b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from June, 1955, to April 20, 1955, that I last saw the deceased alive on 4-20, 1955, and that death occurred at 6:35 P.M., from the causes and on the date stated above.

SIGNATURE Marion C. Partridge M.D. (Degree or title) ADDRESS Hampstead, Md. DATE SIGNED 4-22-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 23/55</u>	<u>Hercford Bapt. Cem.</u>	<u>Hercford, Balto., Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/23/55</u>	<u>Leaher & Butler</u>	<u>Jacob Fortenstein</u>	<u>New Freedom, Pa.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 2 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03427
3449
CERTIFICATE OF DEATH

Reg. Dist. No. X

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>HOWARD</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>FORT HOWARD</u>		LENGTH OF STAY (in this place) <u>10 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WOODSTOCK</u> <u>13X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>WOODSTOCK COLLEGE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM C. MC CLOSKEY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 21 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>SEPTEMBER 9, 1890</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Woodstock College</u>		11. BIRTHPLACE (State or foreign country): <u>STATEN ISLAND, NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>MICHAEL . MC CLOSKEY</u>				14. MOTHER'S MAIDEN NAME: <u>MARY VANDERVORT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		16. SOCIAL SECURITY No. <u>213-12-6298</u>		17. INFORMANT & ADDRESS: <u>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMA, LEFT LUNG</u>						UNKNOWN	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APRIL 11, 1955</u> , to <u>APRIL 21, 1955</u> , that I last saw the deceased <u>XXXXXXXXXXXXXXXXXXXX</u> and that death occurred at <u>9:15A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>WILLIAM B. VANDEGRIFT, M.D.</u>		ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>4-21-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>April 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>ALPHONSUS CEMETERY</u>		LOCATION (City, town, or county) (State) <u>WOODSTOCK, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-22-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Ellsworth</u> ADDRESS <u>Armacost, Ellsworth, Funeral Chapel 4600 Liberty Heights Avenue, Balto. 7, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C. 20315

TO THE SECRETARY OF THE ARMY

FROM THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

MARYLAND

3450

CERTIFICATE OF DEATH

03428
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) CATONSVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 502 INGLESIDE AVE.		STREET ADDRESS (If rural, give location) 502 INGLESIDE AVE.	
3. NAME OF DECEASED (Type or Print)	(First) ANNA (Middle) MARIE (Last) MC KEE	4. DATE OF DEATH (Month) (Day) (Year) APRIL 25 1955	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH AUG. 8, 1877 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN MC KEE		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mr. Joseph M. Mc Kee, 501 Ingleside Ave.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 Immediate cause (a) Cerebral Arterio Sclerosis			2 1/2 hrs.
Antecedent cause(s) (b) Generalized Arterio Sclerosis			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arterio Sclerosis C.V.D.			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug 1, 1934, to Apr 25, 1955, that I last saw the deceased alive on Apr 24, 1955, and that death occurred at 6 P.M., from the causes and on the date stated above.			
SIGNATURE James S. Howell		ADDRESS Catonville DATE SIGNED 4-26	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 4-27-55	
NAME OF CEMETERY OR CREMATORY Cathedral Cem.		LOCATION (City, town, or county) Bald. (State) MD.	
DATE REC'D BY LOCAL REG. 4/26/55		REGISTRAR'S SIGNATURE V.E. Harry	
24. FUNERAL DIRECTOR Shelley Funeral Home, Catonsville, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR 28 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3451 CERTIFICATE OF DEATH

03429

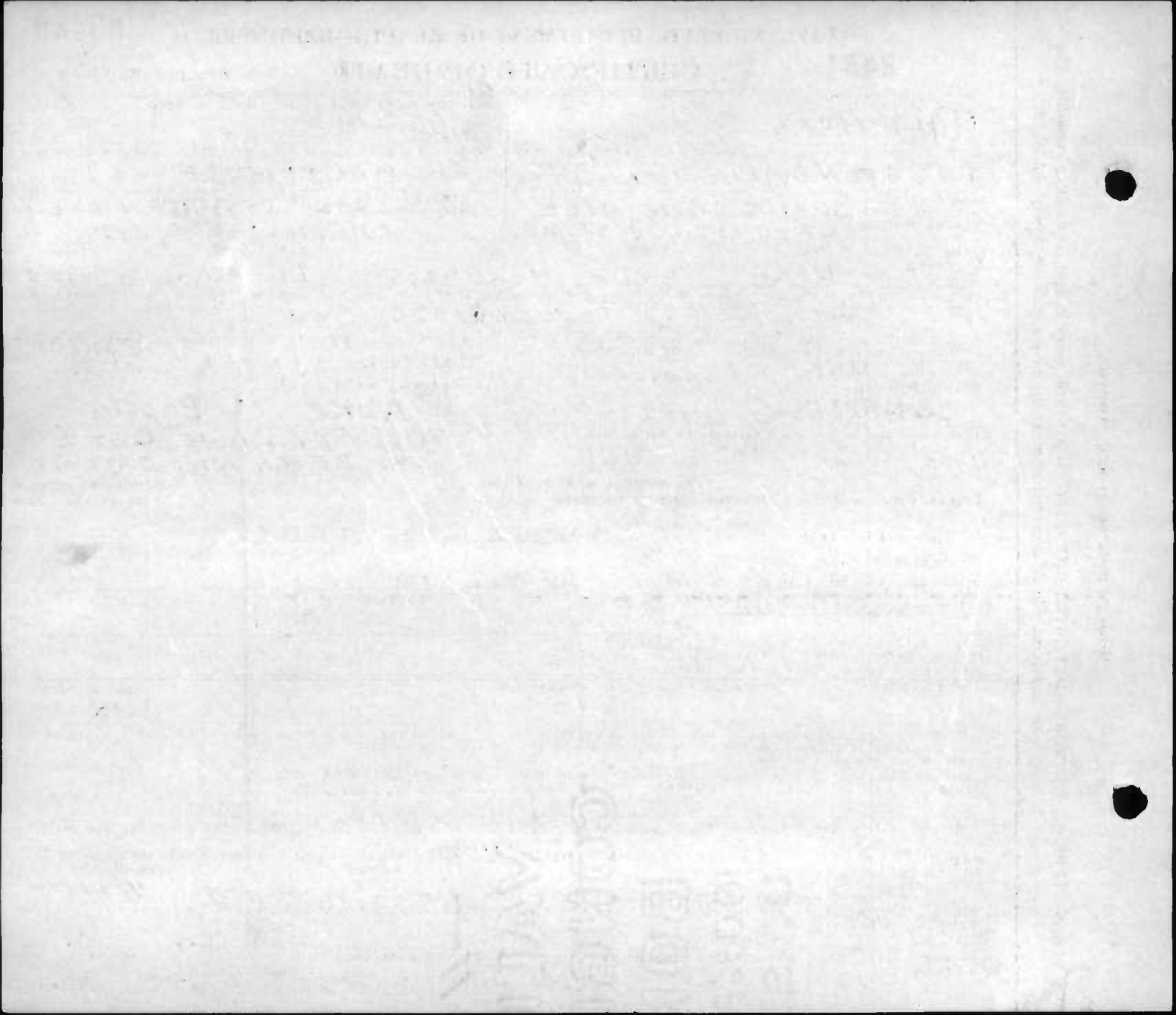
Reg. Dist. No.

1. PLACE OF DEATH: COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL or nearest town) CATONSVILLE TOWN CATONSVILLE HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRING GROVE HOSP. CATONSVILLE 28, MD.		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE TOWN 3401.4 STREET ADDRESS 3902 SOUTHERN AVE. BALTIMORE 6, MD.	
3. NAME OF DECEASED: (First) NORA (Middle) LUZ (Last) MCKENZIE		4. DATE (Month) (Day) (Year) OF DEATH: APRIL 2 1955	
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W	8. DATE OF BIRTH: JULY 1870
9. AGE last birthday: 84 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNK		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): UNITED STATES		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: CHARLES G. Lutz		14. MOTHER'S MAIDEN NAME: ANNE N. BOPST	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): UNK		16. SOCIAL SECURITY NO. UNK	
17. INFORMANT & ADDRESS: MISS BLANCHE LUTZ 3540 BEECH AVE., BALT. MD.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) ARTERIOSCLEROSIS			
ANTECEDENT CAUSE (S) SENILITY			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
22. I hereby certify that I attended the deceased from AUG. 1954 to APR. 2, 1955 that I last saw the deceased alive on APR. 2, 1955 , and that death occurred at 11 PM , from the causes and on the date stated above.			
SIGNATURE Benjamin Blackman		DATE SIGNED 4/2/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-6-1955	
NAME OF CEMETERY OR CREMATORY Good Shepherd		LOCATION (City, town, or county) (State) Rockland Md. Howard Co.,	
DATE REC'D BY LOCAL REGISTRAR 4-4-55		24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3452

MARYLAND STATE DEPARTMENT OF HEALTH

03430

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> 3101-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Notch CLIFF Road.</u>		STREET ADDRESS (If rural, give location) <u>3102 Pelham Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u> (Middle) <u>Walter</u> (Last) <u>McNeill</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb 24, 1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practitioner - Bethlehem Steel</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>27</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> If under 24 hrs. Hours <u> </u> Mins. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A McNeill</u>		14. MOTHER'S MAIDEN NAME <u>M Elizabeth Blank</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr George A McNeill SAME</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>About midnight</u> <u>Seen by</u> <u>Medical Examiner</u> <u>at 2:45 am.</u>
(a) Immediate cause <u>976x Gunshot Wound in Heart</u>		
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		12. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

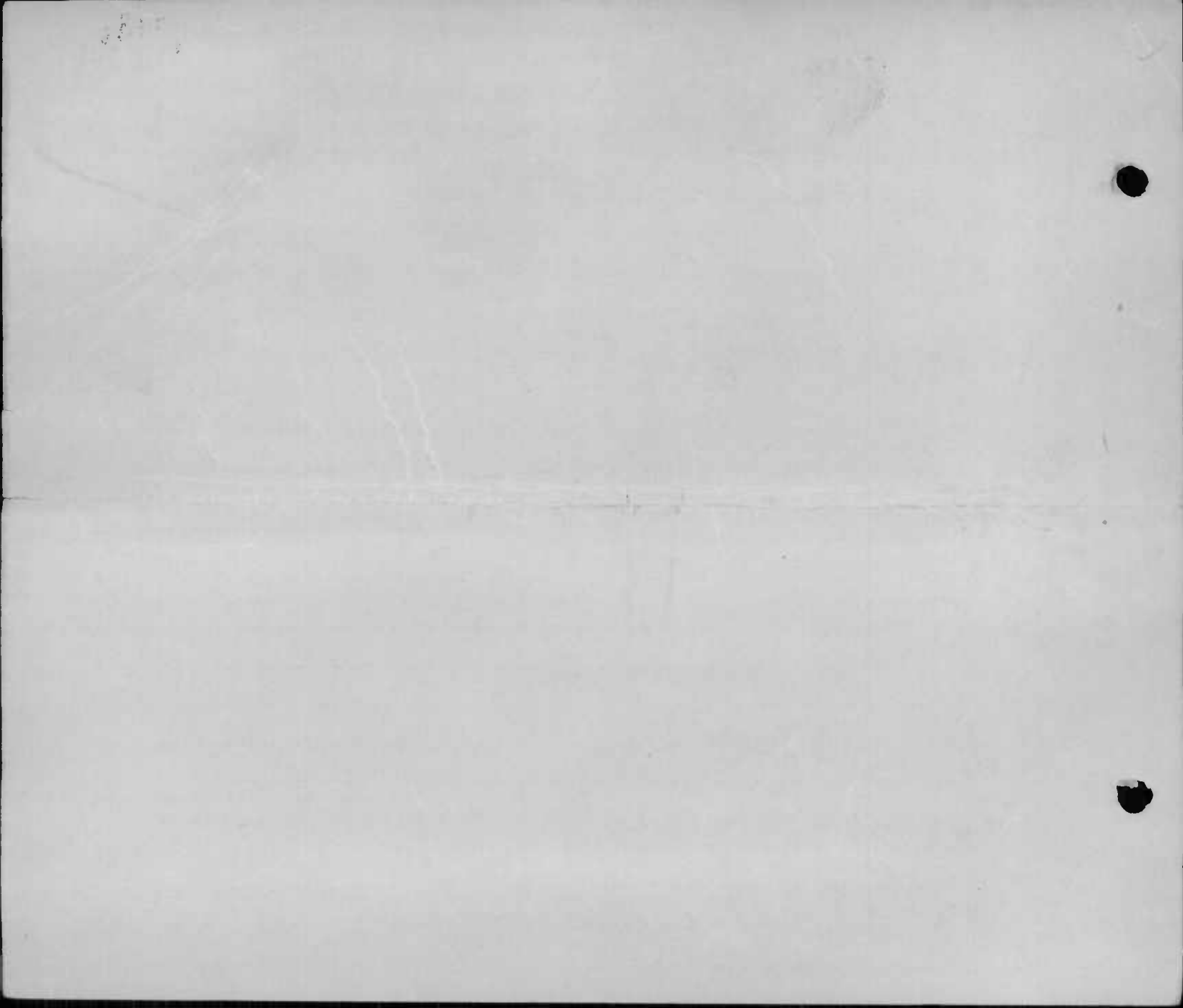
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Charles F. Chonell MD 7501 York Rd Towson 4/1/55

23. BURIAL, CREMATION OR OTHER DISPOSAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-4-55</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	LOCATION (City, town, or county) <u>BALTO Md</u>
DATE REC'D BY LOCAL REG. <u>4-1-55</u>	REGISTRAR'S SIGNATURE <u>A. V. Hedrick</u>	24. FUNERAL DIRECTOR <u>Lernard J. Ruck</u>	ADDRESS <u>5305 Bayford</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3453

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Fort Howard</u>	<u>8 Hrs. 45 Min.</u>	OR TOWN <u>Baltimore</u>	<u>3401-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>50</u> <u>Veterans Administration Hospital</u>		<u>2329 Madison Avenue</u>	<u>✓</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>THOMAS L. MILBURN</u>		<u>April 29, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>7/6/93</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.
<u>Waiter</u>		<u>Hotel</u>	<u>61 yrs</u>
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Baltimore, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Charles H. Milburn</u>		<u>Annabelle Yates</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Yes</u> <u>WW I</u>		<u>212-10-7471</u>	
17. INFORMANT & ADDRESS:			
<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>			<u>1 MONTH</u>
ANTECEDENT CAUSE (S): DUE TO (B) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u>			<u>7 YEARS</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
<u>VA</u> <u>M.</u>		<u>11:00 AM</u> <u>7:45 PM</u>	
22. I hereby certify that <u>X</u> attended the deceased from <u>Apr. 29, 1955</u> to <u>Apr. 29, 1955</u> , that I last saw the deceased <u>live on</u> <u>XXXXXX XXXX</u> and that death occurred at <u>7:45 M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>LOUIS F. HUBNER, M.D.</u>		<u>4/30/55</u>	
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)	
<u>Burial</u> <u>May 5, 1955</u>		<u>Baltimore National</u> <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>2-555</u>		<u>Holland Funeral Home</u> <u>1631 Druid Hill Ave., Balto., Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03432
3454
CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Woodlawn</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2415 Poplar Drive</u>		STREET ADDRESS (If rural give location) <u>2415 Poplar Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>KATHARINE C. MILLER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 29, 1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Dec. 25, 1876</u>
9. AGE last birthday: <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Joseph Maccubbin</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT & ADDRESS: <u>Mrs. W. A. Trautman-2415 Poplar Drive</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>442X</u>			
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) <u>Cardio-vascular-renal disease</u> (B) <u>Myocarditis and arteriosclerosis</u> (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 17, 1955</u> , to <u>April 29, 1955</u> , that I last saw the deceased alive on <u>April 28, 1955</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>L. J. Tolomek M.D.</u>		ADDRESS <u>4710 Liberty Hts</u> DATE SIGNED <u>May 2 '55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/2/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-2-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedgcock</u>	
FUNERAL DIRECTOR <u>Wm. J. Tickner & Sons</u>		ADDRESS <u>Baltimore</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3455

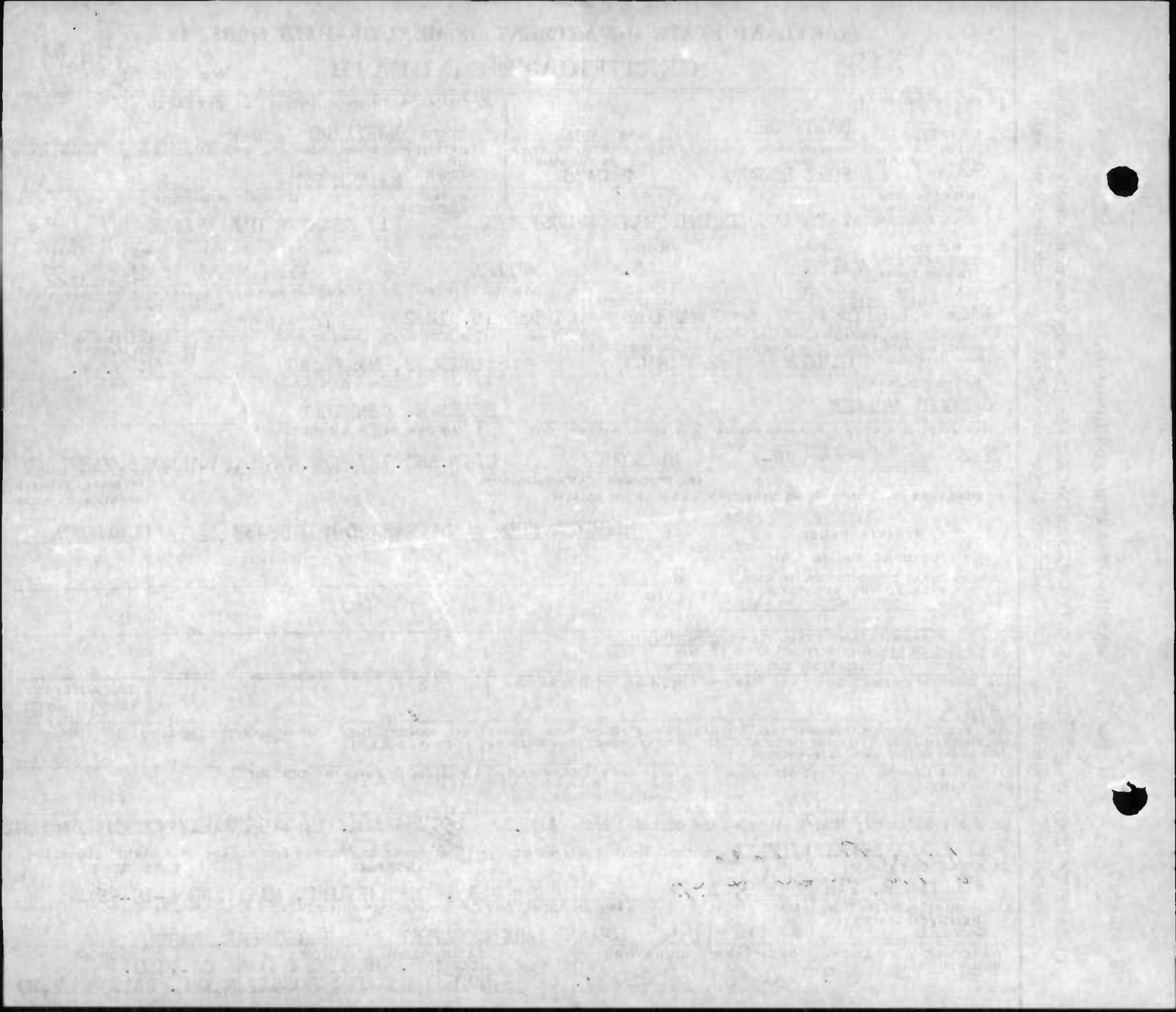
CERTIFICATE OF DEATH

Reg. Dist. No. 03433

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN FORT HOWARD	2 DAYS	TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 417 CHARTER OAK AVENUE	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
WALTER G. MULLEN		OF DEATH: APRIL 14 1955	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: OCTOBER 16, 1882
9. AGE last birthday 72 yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY: ELECTRICAL	11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
13. FATHER'S NAME: GREGORY MULLEN		14. MOTHER'S MAIDEN NAME: HELEN E. DONNELLY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) YES WW-I		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X		UNKNOWN	
IMMEDIATE CAUSE (A) HYPERTENSIVE CARDIOVASCULAR DISEASE			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from APR. 12, 1955 , to APR. 14, 1955 , and that death occurred at 5:15 PM , from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		ADDRESS M. DVAH, FORT HOWARD, MARYLAND 4-15-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4-16-1955	
NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		LOCATION (City, town, or county) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 4-15-55		REGISTRAR'S SIGNATURE Henry W. Jenkins & Sons Co., Inc.	
24. FUNERAL DIRECTOR HENRY W. JENKINS & SONS CO., INC.		ADDRESS 4905 YORK RD & ROSSITER AVE. BALTIMORE, MD	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03434
3456 CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Rural Monkton</u>		<u>70 YRS.</u>		TOWN <u>Monkton</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MANOR Road.</u>				STREET ADDRESS (If rural give location) <u>MANOR Road.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Howard Guy Nelson.</u>				<u>APRIL 8 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>19 FEB 1885</u>	<u>70</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>FARMER</u>				<u>Farm</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>USA.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Howard Nelson</u>				<u>Florence PARKER.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>NO</u>						<u>MRS. Guy NELSON - Monkton, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>490X Bilateral Pneumonia</u>						<u>2 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Advanced Bronchiectasis</u>						<u>3 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT</u> , 1954, to <u>8 April</u> , 1955, that I last saw the deceased alive on <u>8 April</u> , 1955, and that death occurred at <u>9 P M</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Thomas A. E. Monley</u>		<u>Cockeysville, Md.</u>		<u>8 April 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-11-55</u>		<u>St. James</u>		<u>Monkton, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>April 9, 55</u>		<u>M. Elizabeth Gouch</u>		<u>Brooks Funeral Service, Sparks, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 12 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3457 CERTIFICATE OF DEATH

03435

38

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore MARYLAND				STATE Maryland COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson LENGTH OF STAY (in this place)				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 914 Locust Vale Drive				STREET ADDRESS (If rural give location) 914 Locust Vale Drive Apt 4			
3. NAME OF DECEASED: (Type or Print)		(First) Mr. Robert (Middle) Theodore (Last) Neumann		4. DATE (Month) (Day) (Year) OF DEATH: April 3rd 1955			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Jan. 24, 1911	9. AGE last birthday 44 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elect. Maint.		10B. KIND OF BUSINESS OR INDUSTRY: Kaiser		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Mr. Theodore Neuman n				14. MOTHER'S MAIDEN NAME: Emma Aumann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. 220-05-19052		17. INFORMANT & ADDRESS: Mrs. Mary B. Neuman, 914 Locust Vale Dr.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Coronary artery occlusion						6 hours	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/3, 1955 , to 4/3, 1955 , that I last saw the deceased alive on 4/3, 1955 , and that death occurred at 8 A M, from the causes and on the date stated above.							
SIGNATURE Maddeus C. Swinski		ADDRESS 17 W. Penna. Ave. Towson		DATE SIGNED 4/4/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 6, 1955		NAME OF CEMETERY OR CREMATORY Parke wood Cemetery		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 4-5-55		REGISTRAR'S SIGNATURE E. W. Hyland		24. FUNERAL DIRECTOR Leonard J. Ruck		ADDRESS 5305 Harford Road #14	

Dr. Thaddeus Siwinski
17 W. Pennsylvania Ave.
VA 5 3080

10:30 MON

Released by Dr. R.S. Hudson DME.
Town & Ind.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803436

3458

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1530 Taylor Avenue		STREET ADDRESS (If rural give location) 1530 Taylor Avenue	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Mr. Calvin	(Middle) Roache	(Last) Norris	OF DEATH: April 3, 1 1955
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Oct. 1, 1903
9. AGE last birthday 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner Tropical Fish Store		10B. KIND OF BUSINESS OR INDUSTRY: Hagerstown, Maryland	
11. BIRTHPLACE (State or foreign country): USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: ?		14. MOTHER'S MAIDEN NAME: ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-32-6553	
17. INFORMANT & ADDRESS: Mrs. Vera A. Norris 1530 Taylor Ave.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) CORONARY THROMBOSIS			2 HRS
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) CORONARY ARTERIOSCLEROSIS			17 HRS
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/31 , 19 47 , to 4/3 , 19 55 that I last saw the deceased alive on 4/3 , 19 55 , and that death occurred at 8 A.M. , from the causes and on the date stated above.			
SIGNATURE Robert D. Sunday		DATE SIGNED 4/4/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. FUNERAL DIRECTOR ADDRESS	
DATE THEREOF Apr. 6, 1955	NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 4-5-55	REGISTRAR'S SIGNATURE R. W. H. H. H.	24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, 5305 Harford Road #14	

Dr. Stuart Sunday
Calvert & 33rd Street
9 - 11 Monday.

3459

03437
Reg. Dist.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 35

I. PLACE OF DEATH:

COUNTY

Balto.

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN

52 Eatonville

LENGTH OF STAY
(in this place)

13 da

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

14 Spring Grove Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md. COUNTY Balto. City

CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN

Baltimore 3401-4

STREET
ADDRESS (If rural, give location)

3214 St Paul St. ✓

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

GEORGIA SCHRYVER PARRISH

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

apr 8 1953

5. SEX:

F

6. COLOR OR
RACE:

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

widowed Feb 19, 1871

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

84 yrs.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):

unknown

10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

unknown.

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

Edgar M Schryver

14. MOTHER'S MAIDEN NAME:

Louisa Burns

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

NONE

17. INFORMANT & ADDRESS:

Chas. H. Parrish 3214 St Paul St,
Balto, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

Senility & Generalized Arteriosclerosis 2 yrs.

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b) DUE TO

Fractured Pelvis

(c)

INTERVAL BETWEEN
ONSET AND DEATH

2 yrs.

1 mo.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

none.

19a. DATE OF OPERATION:

none

19b. MAJOR FINDING OF OPERATION:

none

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☒
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY

21c. (City or town)

(County)

(State)

Balto.

Md.

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

mar 12 '53 3 M.

21e. INJURY OCCURRED
While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Fall

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

A. D. Caples

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

4-8-55

23. BURIAL, CREMATION,
REMOVAL (Specify):

Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

4/11/55

Dried Ridge Cemetery

Pikesville, Md.

DATE REC'D BY LOCAL
REG.

4/11/55

REGISTRAR'S SIGNATURE

A. D. Caples

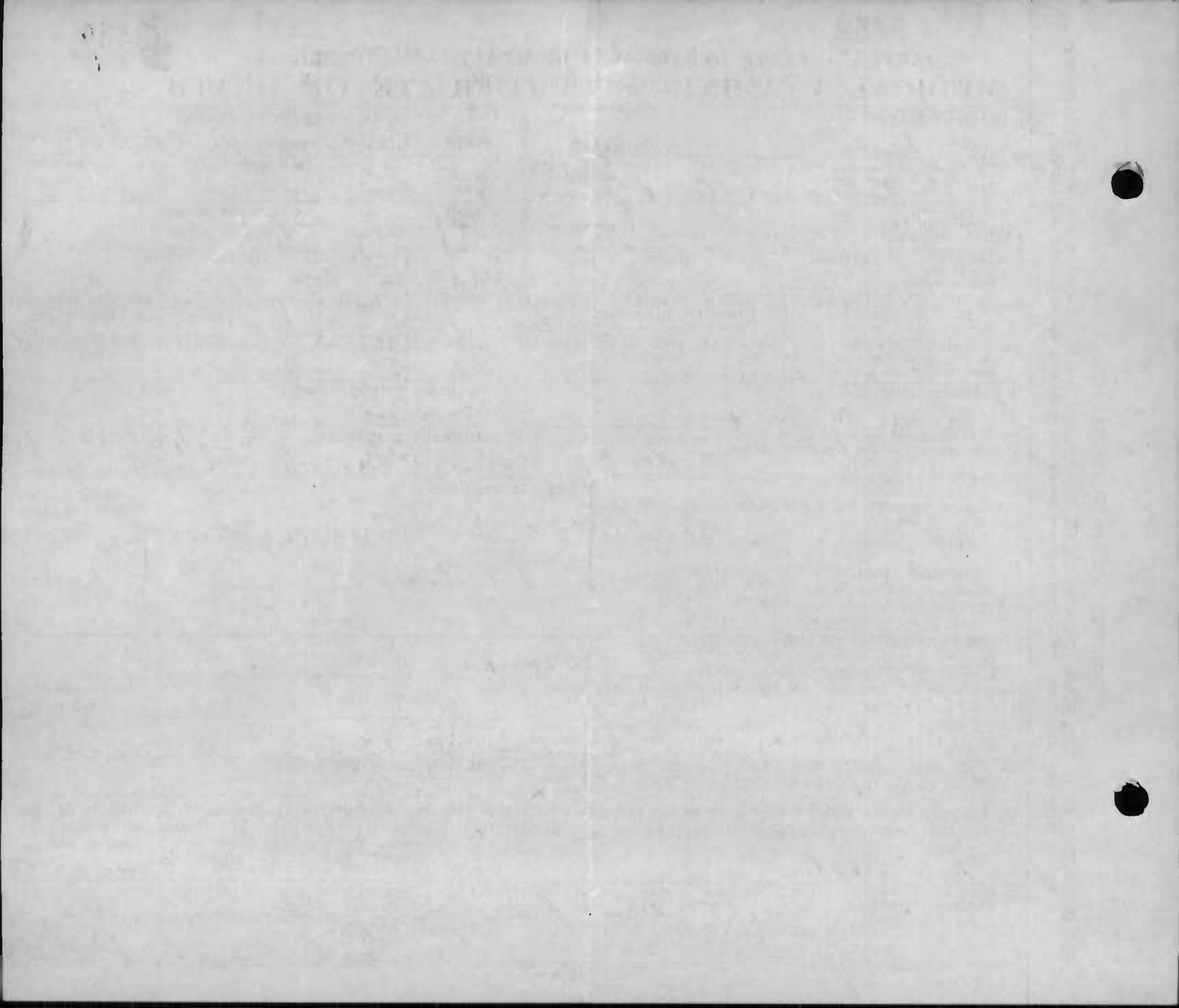
FUNERAL DIRECTOR

Wm. Cook Inc., 1212 E. Paul St.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03438

3364

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>OAK PARK.</u>		LENGTH OF STAY (in this place) <u>4 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>OAK PARK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1905 SHERWOOD RD</u>				STREET ADDRESS (If rural give location) <u>1905 SHERWOOD RD.</u>			
3. NAME OF DECEASED: (Type or Print) <u>BARBARA</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 8 1955</u>			
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>SEPT. 18, 1892</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWORK</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>		9. AGE last birthday <u>62 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>HUNGARY</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>THOMAS SLATER</u>				14. MOTHER'S MAIDEN NAME: <u>ELIZABETH KREITLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT & ADDRESS: <u>ANNA KRALICK 1905 SHERWOOD RD</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
151X IMMEDIATE CAUSE (A) <u>Scirrhus Carcinoma of Stomach</u>						14 mos.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>9/10/54</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Scirrhus Carcinoma of Stomach inoperable</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN 24, 1953</u> , to <u>APRIL 8, 1955</u> , that I last saw the deceased alive on <u>APRIL 8, 1955</u> , and that death occurred at <u>5:30 P M</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. Arthur Kressberg</u>		ADDRESS <u>2436 WASHINGTON BLVD. BALTIMORE 30 Md.</u>		DATE SIGNED <u>4/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 11 55</u>		REGISTRAR'S SIGNATURE <u>Ger Kieffer</u>		24. FUNERAL DIRECTOR <u>Joseph J. Ambrose Jr.</u>		ADDRESS <u>1225 Superior St. Rd.</u>	

2436 W. A. Blvd.

BUREAU V.

APR 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

3460

03439

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Sparks</u> LENGTH OF STAY (in this place) <u>lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparks</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS <u>Belfast Road</u> (If rural give location) <u>1</u>	
3. NAME OF DECEASED (First) <u>Nellie</u> (Middle) <u>Wheeler</u> (Last) <u>Pearce</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>21</u> (Year) <u>1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 7 1889</u>
9. AGE last birthday <u>65</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Evan David Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Ida Rebecca Skippen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Ida Pearce McKee</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

151X Immediate cause (a) Carcinoma stomach with metastases 1 year

Antecedent cause(s) (b) _____

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>July 26 1954</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of stomach with metastases</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 13, 1954, to April 21, 1955, that I last saw the deceasedalive on April 1-20, 1955, and that death occurred at 9:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Elizabeth B. Merrill, M.D. ADDRESS Cockeysville, Md. DATE SIGNED 4/21/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-24-55</u>	NAME OF CEMETERY OR CREMATORY <u>Baileys Methodist</u>	LOCATION (City, town, or county) <u>Sparks, Md.</u>	(State) _____
DATE REC'D BY LOCAL REG. <u>23 April 1955</u>	REGISTRAR'S SIGNATURE <u>Ann Annistead MacRae</u>	24. FUNERAL DIRECTOR <u>Brophy Funeral Service</u>	ADDRESS <u>Sparks, Md.</u>	
<u>J. Scott Brooks</u>				

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 26 1955

BUREAU V. S.

3461 CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>2yr. 1mo. 25days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3Y01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>505 Cathedral Street</u>					
3. NAME OF DECEASED: (Type or Print) <u>Elienora Murray Peck</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 7, 19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>1-27-1870</u>	9. AGE last birthday: <u>85</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George H. Murray</u>				14. MOTHER'S MAIDEN NAME: <u>Dora Purinton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						<u>2 week</u>	
ANTECEDENT CAUSE (S) (B) <u>Coronary arteriosclerosis</u>						<u>Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis</u>						<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-13-</u> , 1953, to <u>4-7-</u> , 1955 that I last saw the deceased alive on <u>4-7-</u> , 1955, and that death occurred at <u>10:45 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>G. Wachser</u>		M. D. <u>Spring Grove State Hospital</u>		DATE SIGNED <u>4-7-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>April 8-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>APR 8 - 1955</u>		REGISTRAR'S SIGNATURE <u>Victor E. [Signature]</u>		24. FUNERAL DIRECTOR <u>Wm Cook Inc - 1217 St Paul St.</u>		ADDRESS	

BUREAU V. S.

APR 18 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 03441

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>ME</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>DUNDALK (221)</u>		LENGTH OF STAY (in this place) <u>28 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>53</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1809 PORTSHIP Rd.</u>				STREET ADDRESS <u>#1</u>		(If rural give location) <u>53</u>	
3. NAME OF DECEASED: (First) <u>ROBERT</u> (Middle) <u>J.</u> (Last) <u>PETERS</u>				4. DATE OF DEATH: (Month) <u>4</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH: <u>OCT. 13, 1875</u>	
				9. AGE last birthday: <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <u>CLERICAL</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>CITY ADMINISTRATION</u>		11. BIRTHPLACE (State or foreign country): <u>PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>ROBERT W. A. PETERS</u>				14. MOTHER'S MAIDEN NAME: <u>LOUISA B. KOHLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>NONE</u>		17. INFORMANT & ADDRESS: <u>DORA A. PETERS - 1809 PORTSHIP Rd.</u>	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<u>150X</u>					
Immediate cause (a) <u>Carcinoma of Esophagus</u>					
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>DUE TO</u>					
(c)					
11. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized Atherosclerosis</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3-25</u> , 19 <u>55</u> , to <u>4-1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-30</u> , 19 <u>55</u> , and that death occurred at <u>7:30 pm</u> , from the causes and on the date stated above.					
SIGNATURE <u>Jack E. Collins, M.D.</u>		(Degree or title)		DATE SIGNED <u>4-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>4-4-55</u>		NAME OF CEMETERY OR CREMATORY <u>WHEATLAND</u>	
LOCATION (City, town, or county) (State) <u>ELK RIDGE, Md.</u>		24. FUNERAL DIRECTOR		ADDRESS <u>2 Kinship Rd. Balt 22</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 2-1955</u>		REGISTRAR'S SIGNATURE <u>William M. Kelly</u>		24. FUNERAL DIRECTOR <u>Ande Brady, Harbort, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 4 1955

BUREAU V. S.

MARYLAND

3462

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 31

Item 3: film 0161 5-12-55 L

1. PLACE OF DEATH: COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) LOCHEARN		CITY (If outside corporate limits, write RURAL and give nearest town) LOCHEARN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3800 LOCHEARN DR.		STREET ADDRESS (If rural, give location) 3800 LOCHEARN DR.	
3. NAME OF DECEASED (First) ANTOINETTE (Middle) PILIPAUSKAS (Last) PHILLIPS		4. DATE OF DEATH (Month) APR. (Day) 29 (Year) 1955	
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH FEB. 14, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	9. AGE last birthday 74 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANULIS		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS MRS MILTON WATTS, 3800 LOCHEARN DR.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
442X Immediate cause (a) Acute Cardiac Failure			1 da
Antecedent cause(s) (b) Cardiovascular Renal Disease			5 yr
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/10 , 19 50 , to 4/29 , 19 55 , that I last saw the deceased alive on 4/29 , 19 55 , and that death occurred at 6:30 a.m. , from the causes and on the date stated above.			
SIGNATURE Joseph S. Lawkarts, MD		ADDRESS 679 Washington Blvd Balto 30 DATE SIGNED 4/30/55	
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE MAY 2, 1955 NAME OF CEMETERY OR CREMATORY LOU DON PARK LOCATION (City, town, or county) BALTO. MD.	
DATE REC'D BY LOCAL REG. 5-1-55		REGISTRAR'S SIGNATURE Angela H. Tinsell	
24. FUNERAL DIRECTOR Harry H. Witzke		ADDRESS 4101 EDMONDSON AVE.	

MARGIN RESERVED FOR BINDING

RECEIVED

MAY 3 1955

BUREAU V. E.

3365

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03443

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>51 TOWN Halethorpe</u>	LENGTH OF STAY (in this place) <u>10 yrs</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>51 Halethorpe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1717 Park ave</u>		STREET ADDRESS (If rural, give location) <u>1717 Park ave</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print) <u>Eloise Louise Plenkner</u>	(First) (Middle) (Last)	<u>April 11 19 1953</u>	
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH: <u>Sept 30 1886</u>
9. AGE last birthday: <u>98</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME: <u>August S. Schaar</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Hoffman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>no</u>	
17. INFORMANT & ADDRESS: <u>Chas. L. Gartrell 1717 Park ave</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>422.1 Immediate cause (a) <u>Acute Cardiac failure</u></p> <p>Antecedent cause(s) (b) <u>Cardiovascular disease</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)	21d. TIME (Month) (Day) (Year) (Hour) OF INJURY
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Dr. J. M. Kieffer 1010 Reddon CHIEF MEDICAL EXAMINER DATE SIGNED April 12 53
M. D. DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>4-14-53</u>	NAME OF CEMETERY OR CREMATORY: <u>Reddon Park</u>	LOCATION (City, town, or county) (State): <u>Balto Md.</u>
DATE REC'D BY LOCAL REG: <u>April 12 53</u>	REGISTRAR'S SIGNATURE: <u>Dr. Kieffer</u>	24. FUNERAL DIRECTOR: <u>Howard H. Hubbard</u>	ADDRESS: <u>4107 Wilkens ave</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 14 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03444
3463 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>P. Gen.</u>	
CITY (If outside corporate limits, write RURAL OR nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (In this place) <u>5 1/2 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville</u> <u>1615-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove Hosp.</u>				STREET ADDRESS (If rural give location) <u>5714 Road St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ELIZABETH POWERS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>4</u> <u>3</u> <u>1955</u>			
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: <u>Oct 10, 1863</u>		9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Cully</u>				14. MOTHER'S MAIDEN NAME: <u>Bridget Cullen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS: <u>5714 Road St</u> <u>Cath. Mansfield Hyattsville, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>450.0</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Senility</u>							
(B) <u>Generalized Arteriosclerosis</u>							
(C) <u>Cerebral Deterioration due to</u>							
(A) and (B).							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/12</u> , 19 <u>45</u> to <u>4/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/3</u> , 19 <u>55</u> , and that death occurred at <u>1 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Spring Grove State Hospital.</u>		ADDRESS <u>FREDERICK</u>		DATE SIGNED <u>4/2/55.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/5/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		24. FUNERAL DIRECTOR <u>Nalley's Funeral Home</u>		ADDRESS <u>3205 R. Lane</u> <u>mt Rainier, Md</u>	

RECEIVED
APR 5 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03445

3462

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> #6	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Best Stet Hse.</u>		STREET ADDRESS (If rural, give location) <u>9532 Belair Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Maynard</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 16 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>9/18/1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stet Co.</u>	9. AGE last birthday <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew Reckert</u>		14. MOTHER'S MAIDEN NAME <u>Maria E. Gould</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Nora Reckert 9532 Belair Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF DEATH Apr - 16 - 55 10AINJURY OCCURRED
While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

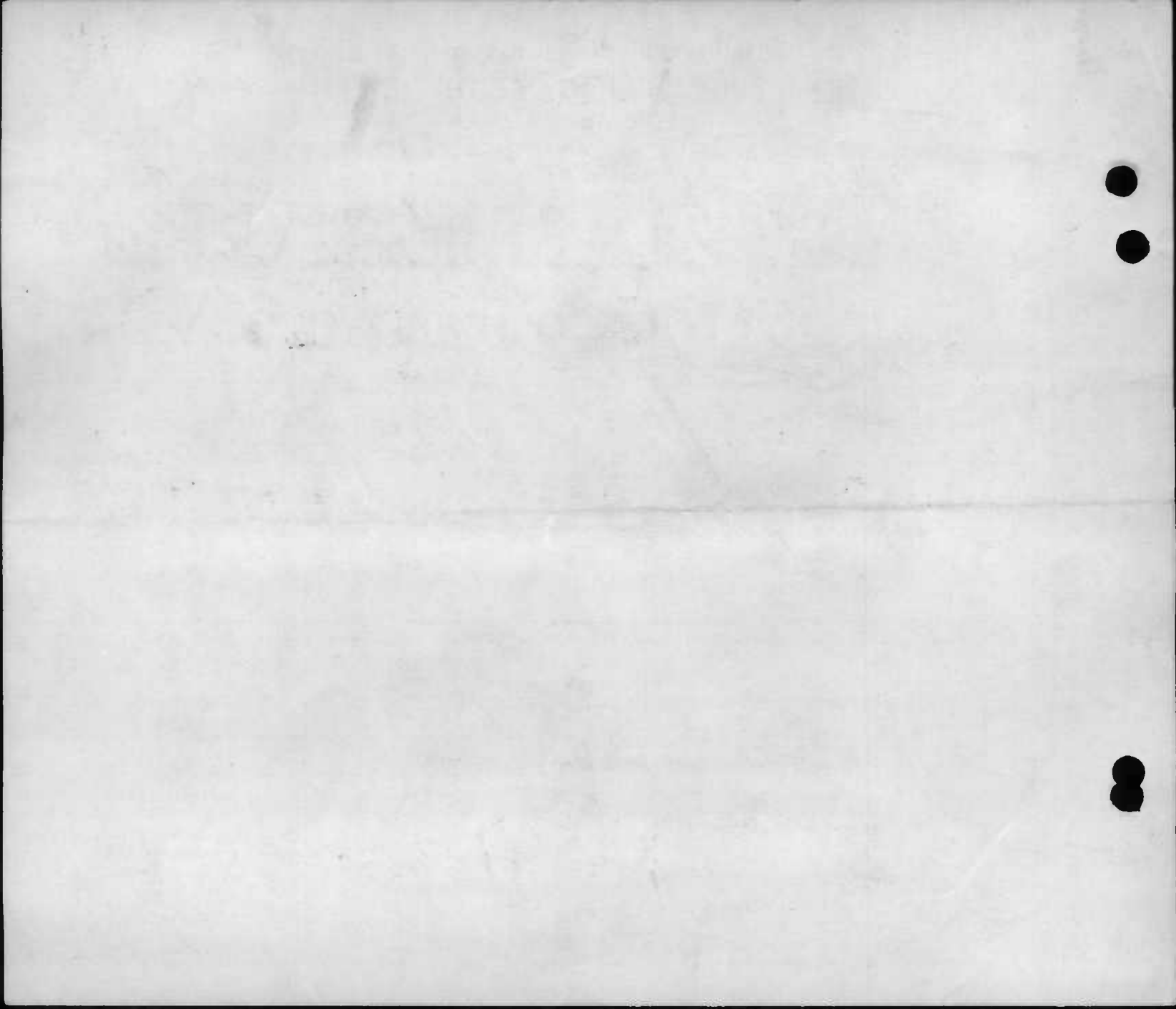
4-18-55

A W. DeBugh

Wm Cook Inc 1217 St. Paul St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3465 MARYLAND. STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03446			
CERTIFICATE OF DEATH			
Reg. Dist. No. 37			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) Parkville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parkville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2628 Wentworth Road #14		STREET ADDRESS (If rural give location) 2628 Wentworth Road #14	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Mr. Frederick (Fritz) Paul Reich		April 7th 19 55	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Oct. 6, 1902
9. AGE last birthday 52 yrs.		10. DATE OF DEATH: April 7th 19 55	
11. BIRTHPLACE (State or foreign country): Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Mr. Julius Reich		14. MOTHER'S MAIDEN NAME: Ida Kupser	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-07-5439	
17. INFORMANT & ADDRESS: Mrs. Elsie W. Reich, 2628 Wentworth Road			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Bronchogenic Carcinoma			
ANTECEDENT CAUSE (B) with generalized metastases			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 15, 1954 , to Apr. 8, 1955 , that I last saw the deceased alive on Apr. 7, 1955 , and that death occurred at 3:00 P. M, from the causes and on the date stated above.			
SIGNATURE Notman Janney		ADDRESS 7101 Harford Rd. DATE SIGNED 4/8/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 11, 1955	
NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR April 9 1955		REGISTRAR'S SIGNATURE R. W.	
24. FUNERAL DIRECTOR		ADDRESS Leonard J. Ruck 5305 Harford Road #14	

Dr. Janney
7101 Harford Road
Friday 9 - 10 A.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03447

3358

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH: COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto 22</u> LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1840 North Pt Rd</u>		STREET ADDRESS (If rural, give location) <u>1840 North Pt Rd</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Elizabeth A Reinecke</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 19 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan 19-1972</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>83 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Balto Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Mary</u>		14. MOTHER'S MAIDEN NAME <u>-</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Miss Gertrude Reinecke North Pt Rd</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

175X

Immediate cause

(a) Generalized Carcinomatosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Malignancy of left ovary(c) Initial Stenosis + Regurgitation

INTERVAL BETWEEN ONSET AND DEATH

1 year

16 months

10 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐22. I hereby certify that I attended the deceased from May 45, 1945, to Apr 19, 1955, that I last saw the deceasedalive on Apr 19, 1955, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Marie A. GasserMD1010 North Point Road4/21/55

23. BURIAL, CREMATION (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial4/22/55Oak Lawn CEMBalto md

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 27-1955William M KellyFuneral Home7401 Balair Rd

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Jacobs

1001 North pt Rd

BUREAU V. S.

APR 29 1955

RECEIVED

3466

CERTIFICATE OF DEATH

03448

Reg. Dist. No. 44

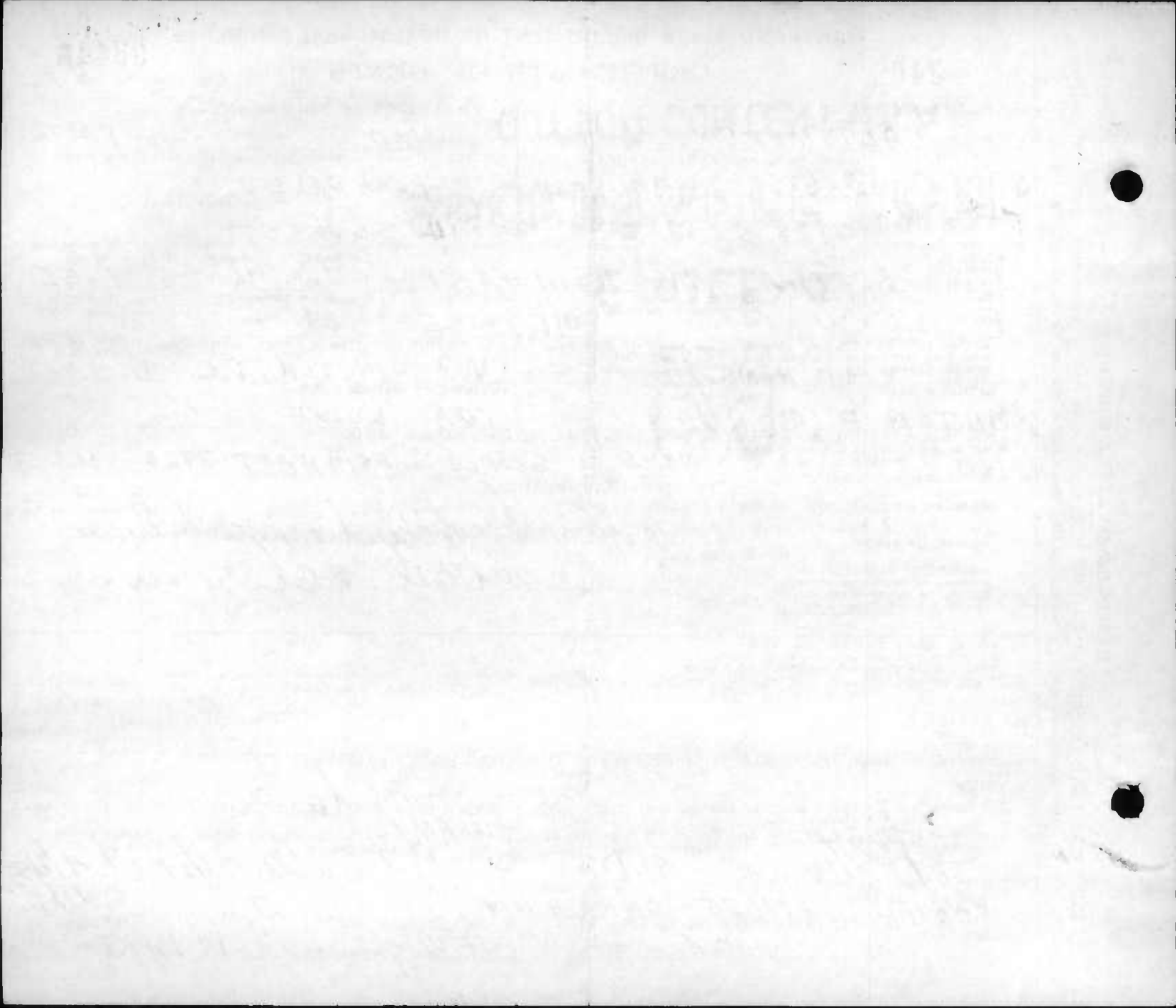
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MD.		COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROSEDALE		LENGTH OF STAY (in this place) APPROX. 50 YRS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROSEDALE		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7924 33rd ST.				STREET ADDRESS (If rural give location) 7924 33rd ST.		X	
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) BERTHA		(Middle) M.		(Last) REINHART		(Month) 4 (Day) 6 (Year) 1955	
5. SEX: F		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED		8. DATE OF BIRTH: 11/12/1885	
9. AGE last birthday: 69 yrs.		10. MONTHS: 6		11. DAYS: 6		12. HOURS: 19 MIN.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: AT HOME				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.	
13. FATHER'S NAME: MILTON F. MORGAN				14. MOTHER'S MAIDEN NAME: IDA LOWE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO				16. SOCIAL SECURITY No.: NONE		17. INFORMANT & ADDRESS: GEORGE S. REINHART 7924 33rd ST.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
422.1 Immediate cause		(a) Arteriosclerotic Cardio-Vascular Disease	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(b) Cerebral Sclerosis.	
(c)			

11. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from May 1951 , to April 6, 1955 , that I last saw the deceased alive on April 5, 1955 , and that death occurred at 12:40 AM from the causes and on the date stated above.							
SIGNATURE J.B. Stevens		(Degree or title) M.D.		ADDRESS 3400 Erdman Ave. Balto. 13 Md.		DATE SIGNED 4/6/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		4/19/55		OAK LAWN		BALTO. MD.	
DATE REC'D BY LOCAL REGISTRAR 4-7-55		REGISTRAR'S SIGNATURE aw		24. FUNERAL DIRECTOR C.F. Hoffmann		ADDRESS 2219 LAKE ave.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3451

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03449

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL or give nearest town) X TOWN FORT HOWARD		LENGTH OF STAY (in this place) 191 Days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 2767 West North Avenue					
3. NAME OF DECEASED: (First) (Middle) (Last) LEON A. RICHARDSON				4. DATE (Month) (Day) (Year) OF DEATH: April 23, 1955			
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH: 5-27-96	9. AGE last birthday 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator Opr.		10B. KIND OF BUSINESS OR INDUSTRY: Factory		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: EPHRAIM RICHARDSON				14. MOTHER'S MAIDEN NAME: ESTHER REISTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 216-07-7346		17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 150X CARCINOMA OF ESOPHAGUS WITH METASTASES				13 Months			
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 10-25-54		19B. MAJOR FINDINGS OF OPERATION ESOPHAGOSCOPY-Finding of Carcinomatous tissue in Esophagus		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that VA attended the deceased from Oct. 14, 1954 to April 23, 1955 and that death occurred at 4:10 PM. from the causes and on the date stated above.							
SIGNATURE J. BARANOWSKI, M.D.		ADDRESS M. D. VAH, Ft. Howard, Md.		DATE SIGNED 4/24/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/27/55		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 5-5-55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Arlington S. Phillips Funeral Home		ADDRESS 1808 N. Monroe St. Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF THE INTERIOR

MINERAL LANDS

OFFICE OF THE

RECORDS

WASHINGTON, D. C.

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RECEIVED

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3359

CERTIFICATE OF DEATH

Reg. Dist. No.

03450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>DUNDALK 22</u>		<u>18</u>		TOWN <u>DUNDALK (22)</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>110 VENTNOR TERRACE</u>				STREET ADDRESS (If rural give location) <u>110 VENTNOR TERRACE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>ROY SAMUEL RIDENOUR</u>				<u>4 13 19 55</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>OCT. 13, 1899</u>	
9. AGE last birthday: <u>55</u> yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>POWER HELPER</u>		11. BIRTHPLACE (State or foreign country): <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>CLARK RIDENOUR</u>		14. MOTHER'S MAIDEN NAME: <u>CORA HOOVER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u>		16. SOCIAL SECURITY No.: <u>213-07-4373</u>	
17. INFORMANT & ADDRESS: <u>ANN H. RIDENOUR - SAME ADDRESS</u>		18. MEDICAL CERTIFICATION		Interval Between Onset And Death: <u>24 hrs.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <u>331X</u> (a) <u>Cerebral Accident</u>							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>DUE TO</u>							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Ca of Lower Esophagus & Cardiac Portion of Stomach</u>							
19a. DATE OF OPERATION: <u>Aug 15, 1954</u>				19b. MAJOR FINDINGS OF OPERATION: <u>Same as 11 - Pericard & Anastomosis</u>			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 1954</u> , to <u>April 13, 1955</u> , that I last saw the deceased alive on <u>April 12, 1955</u> , and that death occurred at <u>3:30 a.m.</u> from the causes and on the date stated above.				DATE SIGNED <u>4/14/55</u>			
SIGNATURE <u>William M. Kelly</u>				ADDRESS <u>Dundalk, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4-15-55</u>		<u>MEADOWRIDGE</u>		<u>DORSEY, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-14-55</u>		<u>William M. Kelly</u>		<u>Walter R. Kelly, Dundalk, Md.</u>			

MARGIN RESERVED FOR BINDING

RECEIVED

APR 15 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Henover Dorsey</u> 02X-2 STREET ADDRESS (If rural give location) <u>RFD Forest Ave.</u> ✓	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>William H. Riley</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>April 13, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12-23-1864</u>
9. AGE last birthday <u>90</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Storekeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Riley</u>		14. MOTHER'S MAIDEN NAME: <u>Sara A. Camron</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hosp.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>491X</u> IMMEDIATE CAUSE (A) <u>Pulmonary abscesses and empyema</u> DUE TO ANTECEDENT CAUSE (S) (B) <u>Bronchopneumonia</u> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic cardiovascular disease</u> Years			<u>1 week</u> <u>Weeks</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-14-</u> , 19 <u>55</u> , to <u>4-13-</u> , 19 <u>55</u> that I last saw the deceased alive on <u>4-12-</u> , 19 <u>55</u> , and that death occurred at <u>7:10 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Louise Frances Woodward</u> M. D. <u>Spring Grove State Hospital</u> 4-13-55 DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 16, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 16, 1955</u>		REGISTRAR'S SIGNATURE <u>Victor E. Barry Jr</u>	
FUNDAL DIRECTOR <u>W. Singleton</u>		ADDRESS <u>Ellen Burnie, Md</u>	

BUREAU V. 2

APR 20 1955

RECEIVED

3360

03452

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Dundalk</u>	LENGTH OF STAY (In this place) <u>6 yrs</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Dundalk 22</u>	<u>53</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>720 S. 51st.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>Ida</u> (Middle) <u>Rodgers</u> (Last) <u>Rodgers</u>		(Month) <u>April</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Sept 17/1875</u>
9. AGE last birthday: <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Henry Schul.</u>		14. MOTHER'S MAIDEN NAME: <u>Minnie Sillinger.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Mrs. Minnie Sillinger.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause		(a) <u>Coronary occlusion</u>	<u>1/2 hr.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(b) <u>Card. Vas Renal Disease</u>	<u>over 15 yrs.</u>
(c)			

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)	21d. TIME (Month) (Day) (Year) (Hour) OF <u>DEATH</u> <u>4 17 1955 3P</u>
21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE M. D. Carmine M.D. M. D. John L. Miller DEPUTY MEDICAL EXAMINER 2334 Jefferson St. DATE SIGNED 4-19-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF April 21/55 NAME OF CEMETERY OR CREMATORY Mt. Carmel Cem. LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REG. 4-19-55 REGISTRAR'S SIGNATURE A. W. Pedersen FUNERAL DIRECTOR John L. Miller ADDRESS 2334 Jefferson St.

158150

0352

RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C.

[Faint, mostly illegible text covering the majority of the page, likely a memorandum or report.]

3469

CERTIFICATE OF DEATH

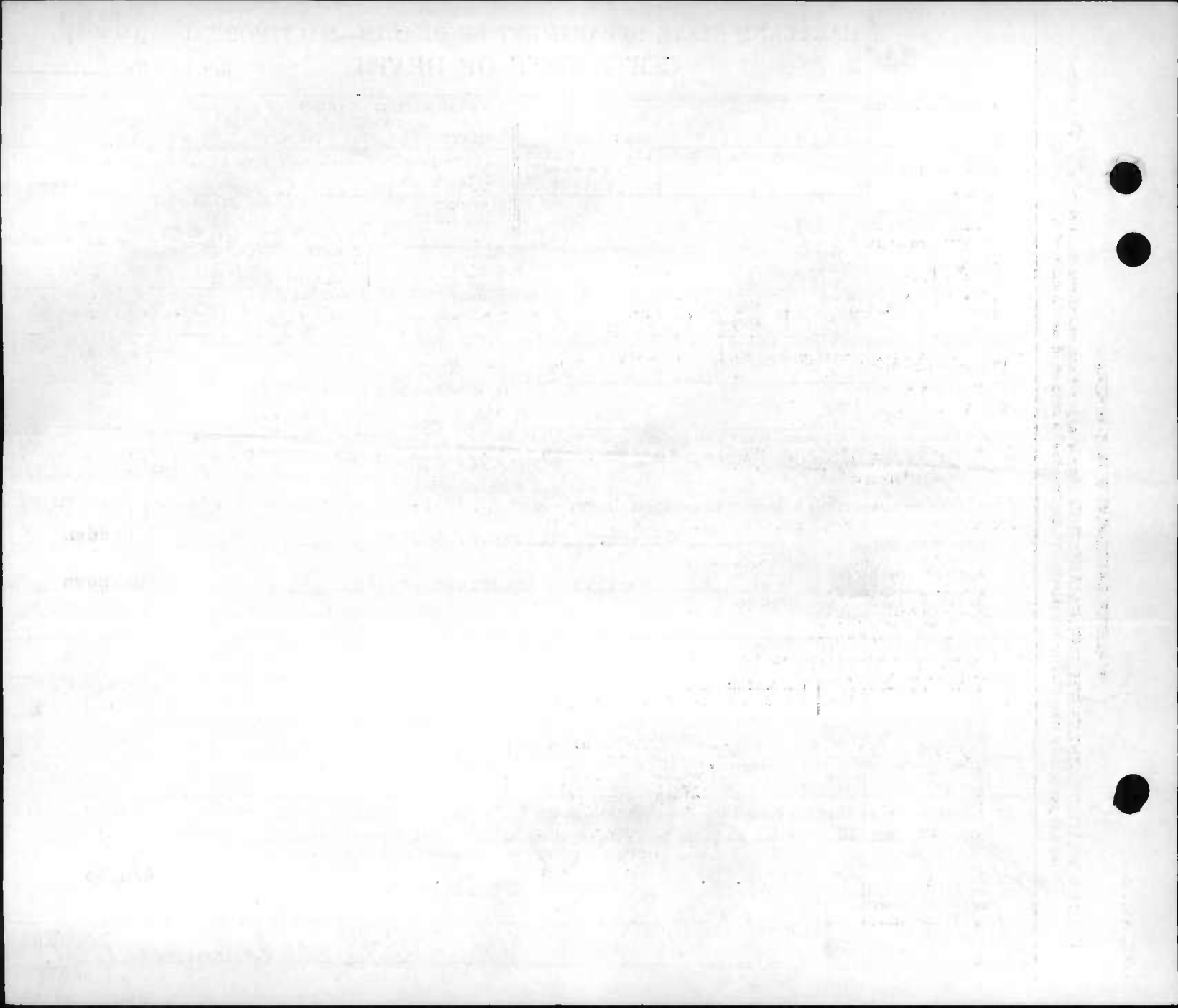
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Woodlawn</u>		<u>3 yrs.</u>		TOWN <u>Woodlawn</u>		OR	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural, give location)	
<u>2127 Southland Road</u>				<u>2127 Southland Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>BERNARD - ROSE</u>				<u>Apr 7 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Widowed</u>		<u>Feb 18, 1871</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <u>84</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Germany</u>	
<u>Retired</u>		<u>Paint Contractor</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Julius Rose</u>				14. MOTHER'S MAIDEN NAME: <u>Maria Saffray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>no</u>		<u>Mildred R. De Rucka, 2127 Southland Rd. 7.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion, Acute</u>						<u>Sudden</u>	
DUE TO							
Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
DUE TO (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>1950</u>				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>June</u>, 19 <u>50</u> ., to <u>April</u> ... <u>7</u> ., 19 <u>55</u> ., that I last saw the deceased alive on <u>Jan. 22</u>, 19 <u>55</u> , and that death occurred at <u>5 P</u>m., from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. Gara M. D.</u>				(DEGREE OR TITLE) ADDRESS <u>1 Mallow Hill Ave.</u>		DATE SIGNED <u>4/8/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Apr 11 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG. <u>Apr 9. 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>John H. Trefel</u>		ADDRESS <u>5311 Edmondson Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3470

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Timonium</u> LENGTH OF STAY (In this place) <u>3 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Timonium</u> STREET ADDRESS <u>113 Northwood Drive</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>113 Northwood Drive</u>			
3. NAME OF DECEASED (Type or Print)	(First) <u>Russell</u> (Middle) <u>Harold</u> (Last) <u>Rosier</u>	4. DATE OF DEATH	(Month) <u>April</u> (Day) <u>25</u> (Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 13, 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	9. AGE last birthday <u>40</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>
13. FATHER'S NAME <u>Emanuel Rosier</u>	14. MOTHER'S MAIDEN NAME <u>Mary B. Cummings</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY No. <u>219-03-4239</u>	17. INFORMANT AND ADDRESS <u>Mrs. Dorothy Rosier, 113 Northwood Drive, Timonium, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Heart disease, vascular, coronary occlusion</u>		<u>Sudden</u>	
Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Rollin C. Hudson M.D., D.M.E.</u>		DATE SIGNED <u>4/25/55</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>	
DATE REC'D BY LOCAL HEALTH OFFICER <u>Apr 26 1955</u>		LOCATION (City, town, or county) <u>New Freedom, York Co., Penna.</u>	
REGISTERER'S SIGNATURE <u>Philip J. Sullivan</u>		24. FUNERAL DIRECTOR <u>Jacob Scharstein</u>	
		ADDRESS <u>New Freedom, Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

MAY 2 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

3471

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> — MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville, Md</u>		STATE <u>Maryland</u> COUNTY <u>Balt</u>		CITY (If outside corporate limits, write RURAL, and give nearest town) <u>52 Catonsville Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		LENGTH OF STAY (in this place) <u>1 year</u>		TOWN <u>1</u>		STREET ADDRESS (If rural give location) <u>no telephone road</u>	
3. NAME OF DECEASED: (Type or Print) <u>William E. Rust</u> (First) (Middle) (Last)				4. DATE OF DEATH: <u>April 2nd</u> (Month) (Day) (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct 8th 1884</u>	9. AGE last birthday: <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. <u>24</u> Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <u>Seaman U.S. Navy</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
13. FATHER'S NAME: <u>August Rust</u>				14. MOTHER'S MAIDEN NAME: <u>Madge Harris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>217-07-4238</u>				16. SOCIAL SECURITY No.: <u>217-07-4238</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Marie Rust 4010 Longwood Rd Catonsville Md</u>				18. MEDICAL CERTIFICATION			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death	
(a) <u>491X Immediate cause</u> <u>Bronchopneumonia</u>				<u>3 days</u>	
(b) Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <u>cerebral hemorrhage</u>					
(c) <u>90 days</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: <u>4-1-55</u>				19b. MAJOR FINDINGS OF OPERATION <u>206 S. Gilman St</u>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
m.					
22. I hereby certify that I attended the deceased from <u>1-15</u> , 19 <u>55</u> , to <u>4-2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-1</u> , 19 <u>55</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Nathan Roarin</u>		(Degree or title) <u>MD</u>		ADDRESS <u>206 S. Gilman St</u>	
DATE SIGNED <u>4-4-55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>April 4-55</u>		<u>Greenwood Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-4-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>P. W. Shippert</u>	
				ADDRESS <u>1300 Canton Rd</u>	

R.F.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1912

THE UNIVERSITY OF CHICAGO

THE DIVISION OF THE PHYSICAL SCIENCES

DEPARTMENT OF CHEMISTRY

RESEARCH REPORT

NO. 1

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03456

3472

CERTIFICATE OF DEATH

Reg. Dist. No.

80

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14</u> <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>APRIL 22 1955</u>	
(Type or Print) <u>William</u> <u>Ryland</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>November 30, 1876</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>78</u> yrs.		<u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
<u>U. S.</u>		<u>U. S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>? William Thomas Ryland</u>		<u>? Annie E. Mass</u>	
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Unk.</u>			
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>George Ryland, Pikesville, Maryland</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE		(A) <u>Coronary Thrombosis</u>	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Hypertensive c.v. disease</u>	
		DUE TO	
		(C) <u>Generalized arteriosclerosis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug. 15, 1919</u> , to <u>April 22 1955</u> , that I last saw the deceased alive on <u>April 22</u> , 1955, and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Spring Grove State Hospital, Catonsville, Maryland, U. R. Cowen, M.D.</u>		<u>April 22, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>David Ridge</u>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<u>4/27/55</u>		<u>Pikesville</u>	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>Victor Harry</u>		<u>Frank H. Newell</u>	
		ADDRESS	
		<u>Pikesville</u>	

BUREAU V. S.

APR 27 1955

RECEIVED

3473

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN FORT HOWARD		6 HOURS		BALTIMORE 3401-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 VETERANS ADMINISTRATION HOSPITAL				815 N. Calvert Street			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
GEORGE SAHERSHUK				APRIL 15 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	10. UNDER 1 YEAR	11. UNDER 24 HRS.	
MALE	WHITE	SINGLE	SEPTEMBER 6, 1898	56 yrs.	Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
SOLDIER		RETIRED		KOWEL, POLAND		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
WASH SAHERSHUK				IRENE KOBETZ			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unk.) (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
YES WW-11		213-28-0144		CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
291X IMMEDIATE CAUSE (A) MICROCYTIC ANEMIA							
ANTECEDENT CAUSE (B) DUE TO UNKNOWN							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 12:45 PM 6:45 PM			
VA M.							
22. I hereby certify that I attended the deceased from APR. 15, 1955, to APR. 15, 1955, that I last saw the deceased alive on APR. 15, 1955, and that death occurred at 6:45 P.M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS			
WILLIAM B. VANDEGRIFT, M.D.				M. D. VAH, FORT HOWARD, MARYLAND 4-16-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
REMOVAL		4-16-1955		WOODLAWN CEMETERY		BLUEFIELD, WEST VIRGINIA	
DATE RECD BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
APR 16 1955		William B. Harber		Wm. Cook-Blight, Inc. Funeral Home		6009 Harford Rd., Balto., Md.	
SHIPPED TO: Northfork Funeral Home, Northfork, W. Va.							

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 19 1955

BUREAU V. 2

3474

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>		LENGTH OF STAY (in this place) <u>65 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PIKESVILLE 8</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 Church Lane</u>				STREET ADDRESS (If rural give location) <u>5 Church Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>JAMES COREY SALTER</u>				OF DEATH: <u>APRIL 16 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>AVG. 27 1880</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>BALTIMORE CITY Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>WILLIAM HENRY SALTER</u>				14. MOTHER'S MAIDEN NAME: <u>ALICE CORCY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unk.): <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-143208A</u>		17. INFORMANT & ADDRESS: <u>SAME ADDRESS CATHERINE J. SALTER (WIFE)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>2 mos</u>	
ANTECEDENT CAUSE (B) <u>Ar. Sclerosis</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension</u>						<u>2 yrs.</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify, that I attended the deceased from <u>May 1953</u> to <u>April 16, 1955</u> , that I last saw the deceased alive on <u>April 16, 1955</u> , and that death occurred at <u>5:05</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James G. Miller MD</u>				DATE SIGNED <u>PIKESVILLE-MD 4/18/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>April 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Ridge cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Maatha A. Newell</u>		24. FUNERAL DIRECTOR <u>FRANK H Newell</u>		ADDRESS <u>PIKESVILLE Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 22 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 42

3475

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Landsdowne</u>		TOWN <u>Lansdowne</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS	102 Elizabeth Ave.	STREET ADDRESS (If rural give location)	102 Elizabeth Ave.
3. NAME OF DECEASED: (First) <u>EDWARD</u> (Middle) <u>GEORGE</u> (Last) <u>SCHEMINANT</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Apr.</u> <u>23</u> , 19 <u>55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>July 7, 1880</u>
9. AGE last birthday: <u>74</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Plumbing</u>	11. BIRTHPLACE (State or foreign country): <u>Md.</u>
13. FATHER'S NAME: <u>Charles B. Scheminant</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Crone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-2467</u>	
17. INFORMANT & ADDRESS: <u>Mr. Earl B. Scheminant-35 Elizabeth Ave.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			<u>6 yrs</u>
ANTECEDENT CAUSE (S) (B) <u>ESSENTIAL HYPERTENSION</u>			<u>12 yrs?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CEREBRAL HEMORRHAGE</u>			<u>3 mos</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>JUNE 7, 1947</u> , to <u>APRIL 23, 1955</u> , that I last saw the deceased alive on <u>APRIL 20, 1955</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>C. Patton Rossberg</u>		ADDRESS <u>M. D. 2436 Washington Blvd</u> DATE SIGNED <u>4/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/27/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-26-55</u>		REGISTRAR'S SIGNATURE <u>H.W. Hedrick</u> FUNERAL DIRECTOR <u>Wm. J. Vickers & Sons - Balto.</u> ADDRESS <u>Md.</u>	

MARGIN RESERVED FOR BINDING

COMMISSIONER OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE COMMISSIONER

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03460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3366

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5544 Selma Ave</u>		STREET ADDRESS (If rural, give location) <u>5544 Selma Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Mary Etta Schlickenmaier</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>April 9, 1885</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>70</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis E. Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Ida N. Ireland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>Doris Hutchens - 5544 Selma Ave.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>260X</u> <u>UREMIA</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>DIABETES MELLITUS</u>		
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from JAN, 1947, to APRIL, 1955, that I last saw the deceased alive on 22 APRIL, 1955, and that death occurred at 4 P m., from the causes and on the date stated above.

SIGNATURE <u>George E. Guleau MD</u>		ADDRESS <u>Chesapeake</u>		DATE SIGNED <u>23 April 55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>	
LOCATION (City, town, or county) <u>Balto.</u>		24. FUNERAL DIRECTOR <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
DATE REC'D BY LOCAL REG. <u>April 25, 55</u>		REGISTRAR'S SIGNATURE <u>Lo. Kieffer</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 27 1955

9010 - 100

03461

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3476

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria</u>		STREET ADDRESS (If rural, give location) <u>glenarm Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Floriana Schmitt</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 2, 1869</u>
9. AGE last birthday <u>85</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Pittsburg Pa.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Philip J. Schmitt</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Tittbach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis Sudden

Antecedent cause(s) (b) Arterio sclerotic cardiac renal vascular disease 15 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April, 1952, to April, 1955, that I last saw the deceased alive on March 8, 1955, and that death occurred at 9:15 A. m., from the causes and on the date stated above.

SIGNATURE Charles E. Gerber (Degree or title) ADDRESS 901 S. CONKLING ST. BALTO., MD. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>4-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM. NOTCH CLIFF</u>		LOCATION (City, town, or county) <u>NR</u> (State) <u>TOWSON, MD.</u>	
DATE REC'D BY LOCAL REG. <u>4-20-55</u>		REGISTRAR'S SIGNATURE <u>JST</u>		24. FUNERAL DIRECTOR, ADDRESS <u>Charles E. Gerber 901 S. CONKLING ST. BALTO., MD.</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10/10/11



10/10/11

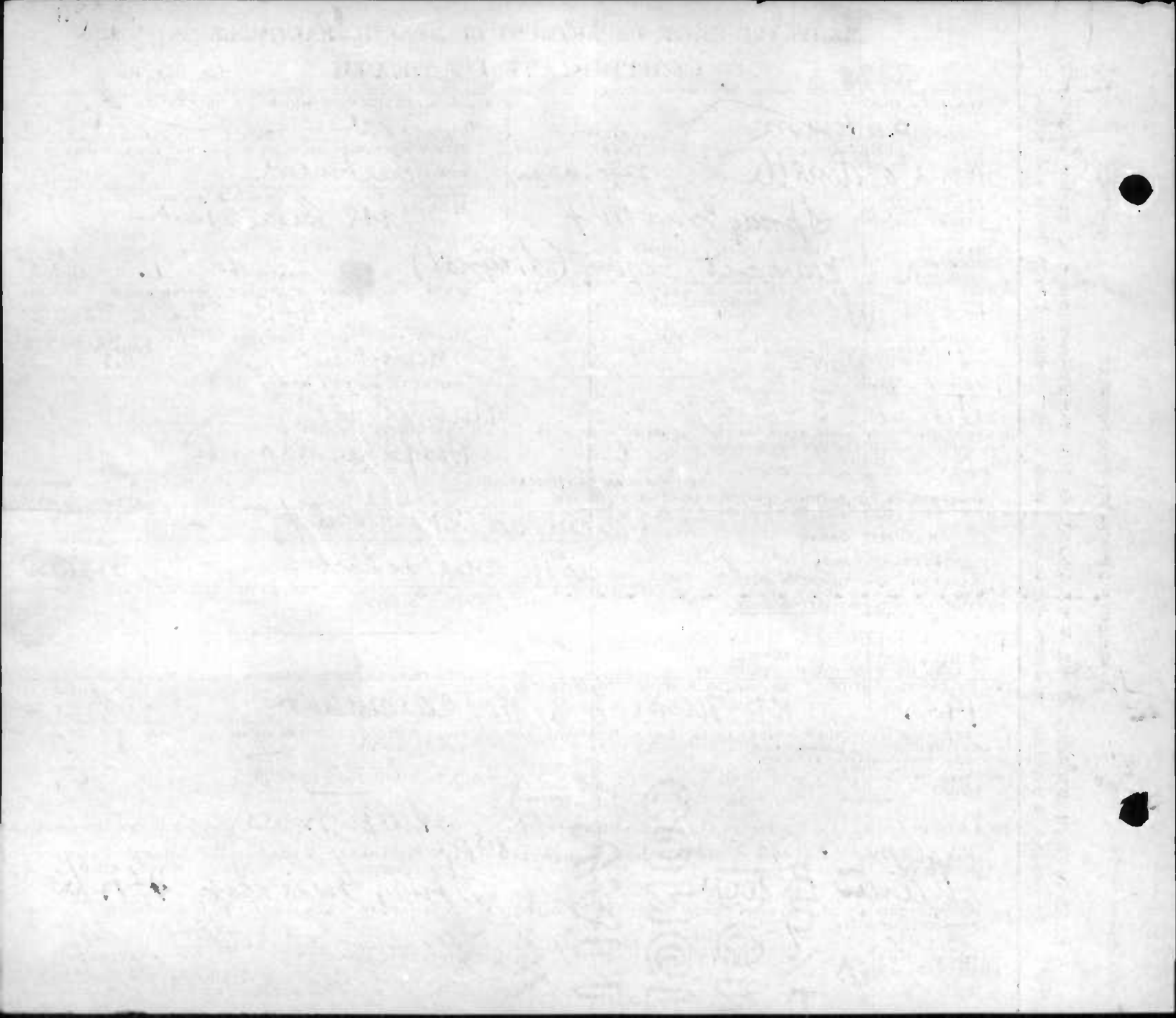
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Jullerton</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>22 yrs. 6 mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hosp.</u>		STREET ADDRESS (If rural give location) <u>748 Belair Rd</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Margaret</u>	(Middle) <u>Segrist</u>	(Last) <u>(diagnosed)</u>	(Month) <u>4</u> (Day) <u>12</u> (Year) <u>1955</u>
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>?</u>
9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NOISE</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jacob ? Segrist</u>		14. MOTHER'S MAIDEN NAME: <u>Mary ? B.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): <u>No</u> If Yes, give war or dates of service: <u>—</u>		16. SOCIAL SECURITY NO.: <u>?</u>	
17. INFORMANT'S ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma Rt. breast</u>			
ANTECEDENT CAUSE (S) DUE TO <u>with metastases</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>1952</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Rt. mastectomy, for carcinoma</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>—</u>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>Sept. 1931</u> , to <u>April 12, 1955</u> , that I last saw the deceased alive on <u>April 12, 1955</u> , and that death occurred at <u>8:15 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles Ward</u>		DATE SIGNED <u>4/12/55</u>	
M. D. <u>Spring Grove Hosp.</u>		ADDRESS <u>305 Harbor</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>4-16-55</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>Apr 15, 1955</u>	REGISTRAR'S SIGNATURE <u>U. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Leonard J. Ruck</u>	ADDRESS <u>305 Harbor</u>



03463

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3367

CERTIFICATE OF DEATH

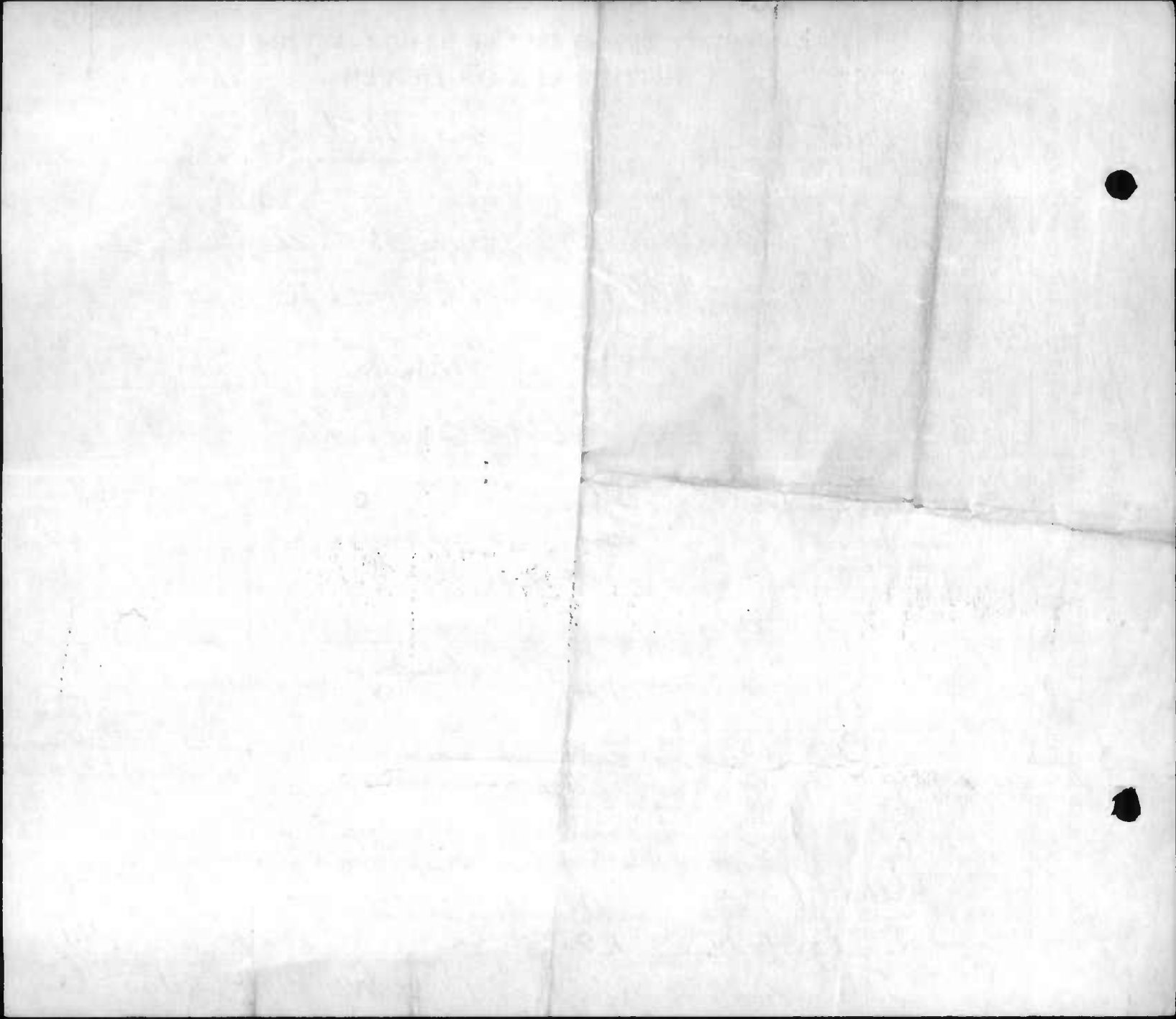
Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)		X			
3. NAME OF DECEASED: (First) <u>DIANE</u> (Middle) <u>CAROL</u> (Last) <u>SILVER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>4</u> - <u>5</u> - <u>1955</u>					
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>Mar. 15</u>	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md</u>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: <u>Nathan Silver</u>				14. MOTHER'S MAIDEN NAME: <u>Lillian Rook</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Nathan Silver -</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Septic & pneumonia</u>						8-12 hrs	
ANTECEDENT CAUSE (B) <u>URI</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prematurity</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 13, 1955</u> , to <u>Apr. 5, 1955</u> , that I last saw the deceased alive on <u>Apr. 2, 1955</u> , and that death occurred at <u>4:55</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Robert J. Davis</u>		ADDRESS <u>4115 W. Rogers Ave</u>		DATE SIGNED <u>4-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-5-55</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Jack Lewis</u>		ADDRESS <u>2100 Eutaw Pl</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

3478

03464

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baynesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baynesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#79 Compens Rd</u>		STREET ADDRESS (If rural, give location) <u>#79 Compens Rd R.F.D. 6</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Anna</u> (Middle) <u>S</u> (Last) <u>Sims</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>April 24-1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE last birthday <u>53</u> yrs.
11. FATHER'S NAME <u>John Traband</u>		12. BIRTHPLACE (State or foreign country) <u>Balto Co md</u>	
13. MOTHER'S MAIDEN NAME <u>Clara Enge</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr Herbert J. Sims #79 Compens Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157X
Immediate cause

(a)

Antecedent cause(s)

Disease or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN
ONSET AND DEATH
5 mos

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office hldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐
(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY m.

INJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/15, 1953, to 4/13, 1955, that I last saw the deceased

alive on 4/13, 1955, and that death occurred at 5:15 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-13-55GTE

Lanshaw Funeral Home 7401. Balim Rd

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Gordon Gray

8523 Loch Raven Blvd

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3479

CERTIFICATE OF DEATH

Reg. Dist. No.

03465

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>P. Kesville</u>		LENGTH OF STAY (in this place) <u>30 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>P. Kesville</u>		OR TOWN <u>8</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>24 WALDRON AVE</u>				STREET ADDRESS (If rural give location) <u>24 WALDRON AVENUE</u>			
3. NAME OF DECEASED: (First) <u>ROBERT</u> (Middle) <u>S</u> (Last) <u>SHERT</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>APR 11</u> <u>6</u> <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE MARRIED. WIDOWED DIVORCED (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>JULY 11, 1891</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKBINDER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>BOOKBINDER</u>		9. AGE last birthday <u>63</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>BALTO. MD</u>	
13. FATHER'S NAME: <u>Michael SHERT</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY No. <u>216-05-1067</u>		14. MOTHER'S MAIDEN NAME: <u>SOPHIA BREHM</u>	
18. MEDICAL CERTIFICATION				17. INFORMANT & ADDRESS: <u>MARY C SHERT</u> <u>same address</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>12 hrs.</u>	
ANTECEDENT CAUSE (B) <u>Coronary Sclerosis</u>						<u>1 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Art. Sclerosis</u>						<u>2 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 1954 to <u>April 6</u> , 1955, that I last saw the deceased alive on <u>April 6</u> , 1955, and that death occurred at <u>6:55 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James A. Mille</u>		ADDRESS <u>Pikesville, Md</u>		DATE SIGNED <u>April 8, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>APRIL 9, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>DROID RIDGE</u>		LOCATION (City, town, or county) (State) <u>Pikesville MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>APR 11 8, 1955</u>		REGISTRAR'S SIGNATURE <u>Louise A. Mille</u>		24. FUNERAL DIRECTOR <u>FRANK H NEWELL</u>		ADDRESS <u>Pikesville MD</u>	

RECEIVED

APR 13 1955

BUREAU V. S.

03466

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3480

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Centreville, M</u> 178-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 571</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. SEX:		6. COLOR OR RACE:	
WILTON D. SPARKS		APRIL 3 1955		Male		White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>2/9/93</u>		9. AGE last birthday: <u>62</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Machanist</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Manufacturing</u>		11. BIRTHPLACE (State or foreign country): <u>Centreville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William S. Sparks</u>				14. MOTHER'S MAIDEN NAME: <u>Mary W. Dulin</u>			
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>214-12-9321</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 WEEKS	
IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>							
ANTECEDENT CAUSE (B) <u>CORONARY THROMBOSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 17, 1955, to April 3, 1955, that I saw the deceased alive on <u>March 17, 1955</u> , and that death occurred at <u>12:01 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Abraham Polachuk, M.D.</u>				DATE SIGNED <u>4/3/55</u>			
ABRAHAM POLACHEK, M.D.				M.D. VAH, FORT HOWARD, MARYLAND			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		April 5 1955		Chesterfield Cemetery		Centreville, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
APR 3 - 1955		<u>[Signature]</u>		Barton Brothers Funeral Home		Centreville, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 6 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03467

Reg. Dist. No. 3/

3481

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Randallstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Randallstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Offutt Road</u>		STREET ADDRESS (If rural, give location) <u>Offutt Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>GEORGE</u> (Middle) <u>EDWARD</u> (Last) <u>SPEALMAN</u>	4. DATE (Month) (Day) (Year) OF DEATH <u>APR. 4th.</u> 19 <u>55</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug. 31st 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired -- Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self House Painter</u>	9. AGE last birthday <u>77 Years</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Spealman</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wesekeer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Edward W. Spealman Offutt Road Randallstown, Maryland</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
157 X Immediate cause (a) <u>Carcinoma of Pancreas</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		(c) _____	
19a. DATE OF OPERATION <u>1954</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Pancreas</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1954, 19....., to 4/4/, 1955, that I last saw the deceased alive on 4/4/, 1955, and that death occurred at 10.40 P.m., from the causes and on the date stated above.

SIGNATURE Wm. E. Martin, M.D. (Degree or title) ADDRESS Randallstown Md DATE SIGNED 4/5/55

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>April, 7th 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	LOCATION (City, town, or county) (State) <u>Randallstown, Balto Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>4/5/55</u>	REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>	FUNERAL DIRECTOR <u>Charles Amoreau</u>	ADDRESS <u>4510 Liberty Heights Ave.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 11 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03468

3482

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

Items 12, 13, 14 Film G181 5-3-55 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gray Manor</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gray Manor</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>7632 Spruce Road</u>	
3. NAME OF DECEASED (Type or Print) <u>John Stachlinski</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Poland</u>
13. FATHER'S NAME <u>Anthony Stachlinski</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Andy Stachlinski son</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
002 X Immediate cause (a) <u>Acute Pneumonitis</u>		<u>7 days</u>
Antecedent cause(s) (b) <u>Pulmonary Tuberculosis</u>		<u>10 year</u>
(c) <u>Arterio-Sclerosis</u>		<u>2</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1955, to Apr 26, 1955, that I last saw the deceased alive on Apr 26, 1955, and that death occurred at 1:50 p m., from the causes and on the date stated above.

SIGNATURE Morris A. Jacob (Degree or title) M.D. ADDRESS 1010 NORTH Point Rd DATE SIGNED 4/27/55
Balto 24. Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF April 29/55 NAME OF CEMETERY OR CREMATORY St Stanislaus LOCATION (City, town, or county) (State)
Baltimore

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Red. Abdul 24. FUNERAL DIRECTOR Fred W Ozarski ADDRESS
4-27-55 1930 Eastern Ave

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3483 CERTIFICATE OF DEATH

03469

Reg. Dist. No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>Gray Manor</u>				<u>Gray Manor</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2600 McComas Ave</u>				STREET ADDRESS (If rural give location) <u>2600 McComas Ave</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
<u>Mary</u> <u>Ann</u> <u>Stanfield</u>				<u>April 14 1955</u>		<u>19</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>white</u>	<u>widow</u>	<u>Sept 22 1882</u>	<u>72</u>	Yrs.	Months	Days
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>at home</u>		<u>at home</u>		<u>Virginia</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Don't know</u>				<u>Don't know</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
				<u>Nannie Lou Stanfield 2600 McComas Ave</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>331X</u> Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>10 hours</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		<u>2 (6 mo)</u>
(b) <u>Diabetes mellitus</u>		
(c) <u>Hypertension</u>		<u>8 years</u>

11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ?
		Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?		

22. I hereby certify that I attended the deceased from Feb, 1955, to Apr 14, 1955, that I last saw the deceased alive on Apr 14, 1955, and that death occurred at 10:30 PM, from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
<u>Morris A. Jacobs MD</u>		<u>1010 North Point Rd Beltsville</u>	<u>4/15/55</u>

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>April 15/55</u>	<u>Huff Cook</u>	<u>Pound, Virginia</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 15-1955</u>	<u>William M. Kelly</u>	<u>Ullrich Funeral Home</u>	<u>2112 Dundalk Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 18 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3484 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

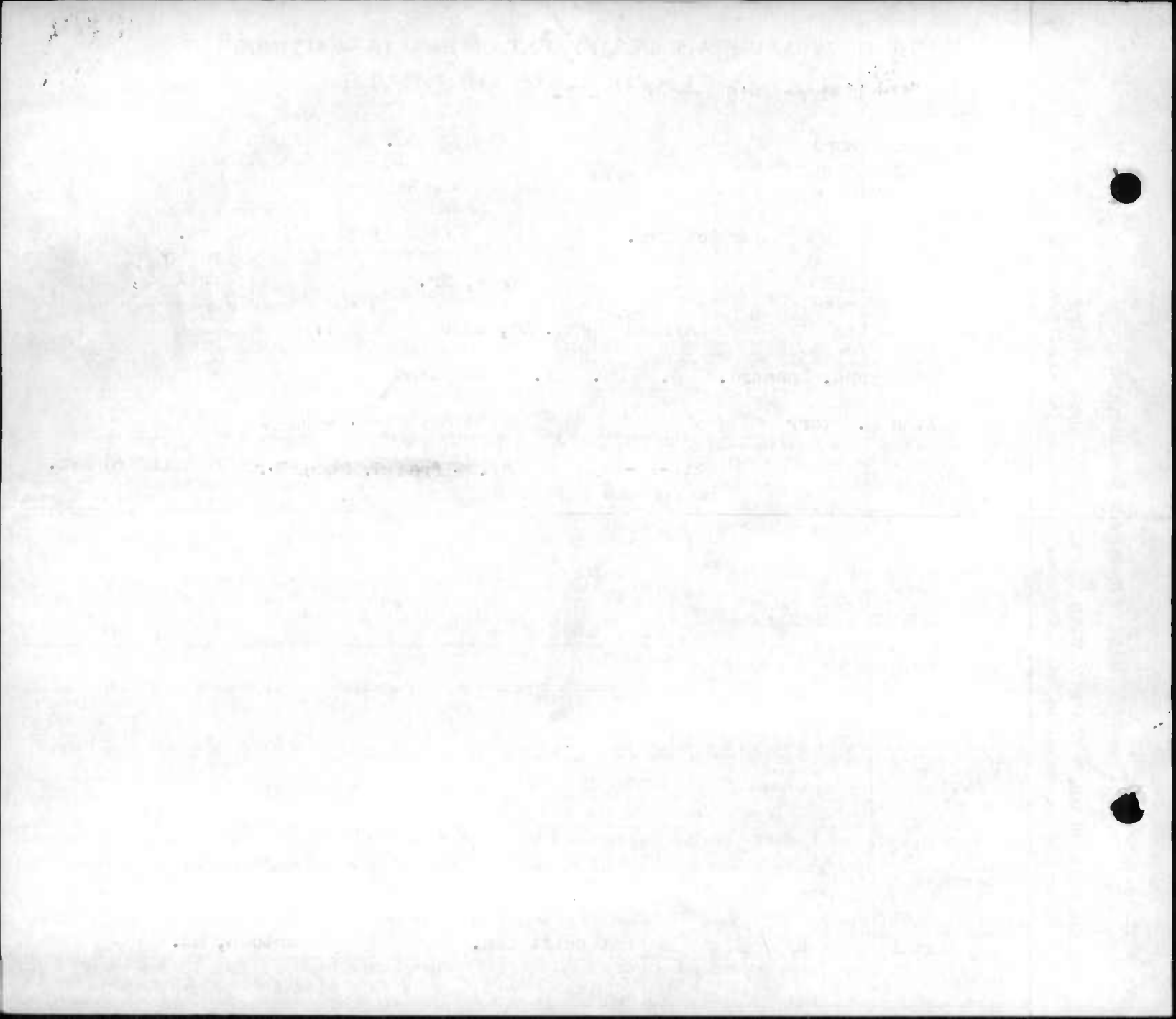
03470

43

Item 4: Funeral director's error: L 4-11-55
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
Overlea		Baltimore	3 Vol. 4
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
104 McCormick Ave.		3026 Guilford Ave.	✓
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
ALFRED GALT STARR, Sr.		April 14, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
male	white	married	Jan. 16, 1878
9. AGE last birthday		10. IF UNDER 1 YEAR	
77 yrs.		Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Maryland			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Milton S. Starr		Catherine E. Longley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		212-10-0636	
17. INFORMANT & ADDRESS:			
Mr. Alfred G. Starr		3026 Guilford Ave.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1			
IMMEDIATE CAUSE (A) DUE TO			Coronary Occlusion
ANTECEDENT CAUSE (B) DUE TO			yr
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) DUE TO			
Hypertension Arteriosclerotic Cardiovascular Disease			
Angina Pectoris			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 17, 1955 , to Apr 2, 1955 , that I last saw the deceased alive on March 17, 1955 , and that death occurred at A.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
J. Frank Dunlap, III (for Dr. Robert Garis)		4/4/55	
M.D. 1014 St Paul St, Balt 2, Md			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		Methodist Cem.	
DATE THEREOF		LOCATION (City, town, or county) (State)	
4/5/55		Uniontown, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
4-4-55		R. W. [Signature]	
FUNERAL DIRECTOR		ADDRESS	
Wm. F. [Signature]		Sons, Balt 17 Md	



3485

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03471

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)52 TOWN Catonsville 28

LENGTH OF STAY

(in this place)
1yr7mos5da

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Baltimore 17HOSPITAL OR
INSTITUTION OR
STREET ADDRESS14 Spring Grove State Hosp.

STREET ADDRESS (If rural give location)

1608 Eutaw Place3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Arthur George Stedman

4. DATE (Month)

(Day)

(Year)

OF

DEATH:

April 1319 55

5. SEX:

Male6. COLOR OR
RACE:White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)Married

8. DATE OF BIRTH:

3/15/1890

9. AGE last birthday

65

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days

Hours Mln.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired)Mechanic10B. KIND OF BUSINESS
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Michigan12. CITIZEN OF WHAT
COUNTRY?USA

13. FATHER'S NAME:

Frank Stedman

14. MOTHER'S MAIDEN NAME:

Ida May White15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unk.) (If Yes, give war or dates
of service)No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

IMMEDIATE CAUSE

(A) Arteriosclerotic cardiovascular disease Years

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

M.

21E. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-23-1953, to 4-13-1955 that I last saw the deceasedalive on 4-12-1955, and that death occurred at 8:45 AM, from the causes and on the date stated above.

SIGNATURE

Loraine Frances Woodward

ADDRESS

Spring Grove State Hospital
Catonsville 28, Maryland

DATE SIGNED

4-13-5523. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-13-55R.W. HedrickW.A. Mitchell1608 Eutaw Place

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE SECRETARY OF THE ARMY

11

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]
[Illegible text follows]

[Illegible text follows]

[Illegible text follows]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3486 CERTIFICATE OF DEATH

Reg. Dist. No. 30

03472

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52</u> TOWN <u>Catonsville 28</u>	LENGTH OF STAY (in this place) <u>18 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>52</u> <u>Catonsville 28</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08</u> <u>24 Wyndcrest Avenue</u>		STREET ADDRESS (If rural give location) <u>24 Wyndcrest Avenue</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last) <u>BESSIE K. STOKES</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 28, 19 55.</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>December 25, 1874</u>
9. AGE last birthday <u>80</u> yrs.		10. AGE UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John F. Arthur</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mr. Harry F. Stokes, Catonsville 28, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE (A) <u>arteriosclerotic cardiovascular disease</u>			<u>5 yrs +</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertrophic + Rheumatoid arthritis</u>			<u>5 yrs +</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1952</u> , 19....., to <u>April 28, 1955</u> , that I last saw the deceased alive on <u>April 27, 1955</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Johna Herbst, Jr.</u>		DATE SIGNED <u>4-29-55</u>	
ADDRESS <u>M. D. 1115 St. Paul St. Balt. 2, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 30, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/29/55</u>		REGISTRAR'S SIGNATURE <u>T. E. Harris</u>	
24. FUNERAL DIRECTOR <u>Coston Sons, Catonsville 28, Md.</u>		ADDRESS	

BUREAU V. S.

MAY 2 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

03473

3487

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE New York COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Timonium		CITY (If outside corporate limits, write RURAL and give nearest town) Yonkers	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Timonium Fair Grounds		STREET ADDRESS (If rural, give location) 29 Holly Street	
3. NAME OF DECEASED (Type or Print)	(First) LYDIA	(Middle) MYERS	(Last) STREHLAU
5. SEX FEMALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	4. DATE OF DEATH April 24, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY American Bk Sta. Co.	8. DATE OF BIRTH July 1, 1904
13. FATHER'S NAME William H. Myers		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
16. SOCIAL SECURITY No.		14. MOTHER'S MAIDEN NAME Lydia M. Murphy	
17. INFORMANT AND ADDRESS Robert B. Strehlau, Yonkers, New York		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause (a) Heart disease, coronary occlusion Antecedent cause(s) (b) Coronary disease with thrombosis (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		HOW DID INJURY OCCUR?	
SIGNATURE Rollin L. Hudson M.D., D.M.E.		DATE SIGNED 4/24/55	
23. BURIAL, CREMATION, REMOVAL (Specify) burial		DATE THEREOF 4/27/55	
NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook, Inc.		ADDRESS 1217 St. Paul Street	

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CERTIFICATE OF DEATH

Reg. Dist. No. 42

3368

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Balto.</i>
CITY (If outside corporate limits, write RURAL OR give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
51 TOWN <i>Arbutus</i>		51 TOWN <i>Arbutus</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1031 Beechfield Ave.</i>		STREET ADDRESS (If rural give location) <i>1031 Beechfield Ave.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>Charles E. Strupp</i>		<i>April 17 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>May 3rd 1897</i>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<i>57 yrs.</i>		<i>Balto, Md.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
<i>Member John Burgoun</i>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Balto, Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Henry Strupp</i>		<i>Louise (Unknown)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<i>Yes</i>		<i>215-03-6645</i>	
17. INFORMANT & ADDRESS:			
<i>Grace Strupp Arbutus</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<i>3 weeks</i>	
420.1 IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>			
ANTECEDENT CAUSE (S) (B) <i>Anginal Syndrome</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Mar 30, 1955</i> , to <i>April 17, 1955</i> , that I last saw the deceased alive on <i>April 16, 1955</i> , and that death occurred at <i>4:30A</i> M, from the causes and on the date stated above.			
SIGNATURE <i>John T. Coolahan</i>		DATE SIGNED <i>4/18/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>London Park Cemetery Baltimore, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4-19-55</i>		24. FUNERAL DIRECTOR ADDRESS <i>Wm Cook Inc. 1217 St. Paul St.</i>	

MAROIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK

IN SENATE
JANUARY 1, 1901

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

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PRINTED BY THE

UNIVERSITY OF THE STATE OF NEW YORK

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03475

Item 3488 engl 81 5-3-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stoneleigh</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>907 Old Oak Rd.</u>				STREET ADDRESS (If rural give location) <u>907 Old Oak Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>OMAR FRED TARR</u>				<u>April 24, 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<u>male</u>	<u>white</u>	<u>married</u>	<u>Dec. 15, 1892</u>	<u>62 5/8</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Vice President</u>				<u>- Chemical Co.</u>		<u>Maine</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Fred P. Tarr</u>				<u>Mary Heme</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>no</u>				<u>215 - 09 - 7262</u>			
17. INFORMANT & ADDRESS:				<u>Mrs. Lenora Tarr-907 Oak Oak Rd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma lung-Bilateral</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 10 1955</u> , to <u>April 24 1955</u> , that I last saw the deceased alive on <u>April 24, 19 55</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Laurence C. Tarr M.D.</u>		<u>6805 York Rd Baltimore 12 Md</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/26/55</u>		<u>Lorraine Maus</u>		<u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-26-55</u>		<u>Ed. Hedrick</u>		<u>Mr. J. Pickner & Sons</u>		<u>Balto, Md.</u>	

CERTIFICATE OF DEATH

FILE NO.

LOCAL HEALTH OFFICE (NAME AND ADDRESS)

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 3/

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>Md</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>WOODLITWN</u>		<u>6 yrs</u>		OR TOWN <u>BALTO. Md 3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>90 AUGSBURG HOME</u>				<u>1422 HOMESTEAD ST. N</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Chiy</u> (First) <u>TEIPE</u> (Middle) (Last)				<u>4</u> / <u>19</u> / <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 YRS.	
<u>Female</u>	<u>White</u>	<u>WIDOW</u>	<u>JULY 15 1868</u>	<u>86</u> yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>BALTO Md.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>CHRISTIAN STECK</u>				<u>LAWRENCE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service)		<u>—</u>		<u>REGORUS AUGSBURG HOME 6811 CAMPFIELD Rd.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u>							
IMMEDIATE CAUSE							
(A) <u>Anterio - Sclerotic Heart</u>							<u>4 yrs.</u>
ANTECEDENT CAUSE (S)							
DUE TO <u>Ischemic -</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
(B)							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>- Generalized Anterio - Sclerotic</u>							<u>5 yrs.</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>None</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 11</u> , 19 <u>51</u> , to <u>April 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 14</u> 19 <u>55</u> , and that death occurred at <u>11:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Paul L. Chambers</u>		<u>4108 Liberty Rd. Balto - 7. Ind</u>		<u>4-19-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or route) (State)	
<u>BURIAL</u>		<u>4/21/55</u>		<u>LORRAINE CEM.</u>		<u>BALTO. Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-20-55</u>		<u>A W Hedgcock</u>		<u>Paul A. Deane</u>		<u>6811 Campfield Rd.</u>	

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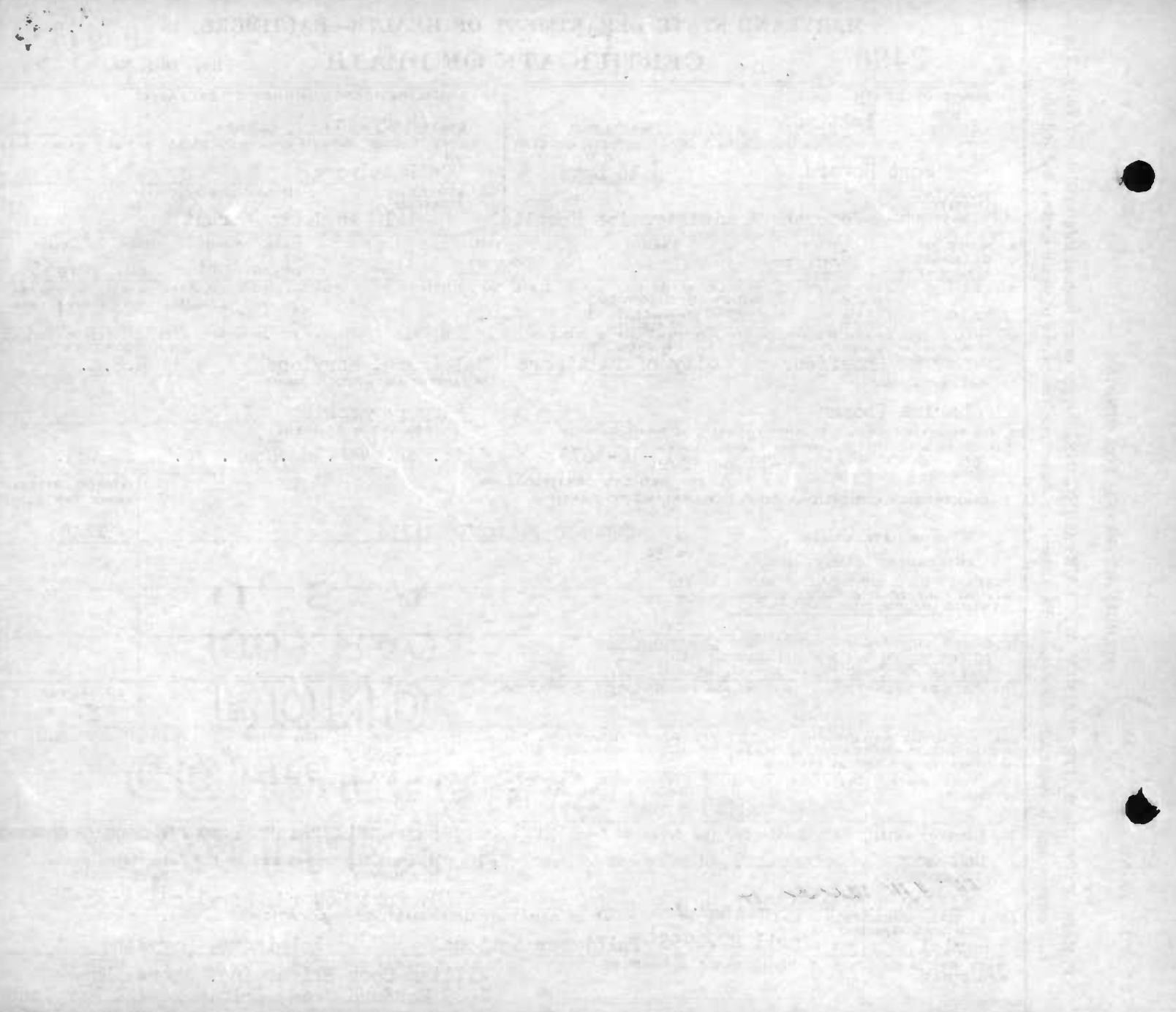
CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Fort Howard		LENGTH OF STAY (in this place) 18 Days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Veterans Administration Hospital		STREET ADDRESS (If rural give location) 1218 Anglesea Street					
3. NAME OF DECEASED: (First) (Middle) (Last) CHARLES P. THOMAS				4. DATE (Month) (Day) (Year) OF DEATH: April 24, 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 6-9-23	9. AGE last birthday 31 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY: City of Baltimore		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Charles Thomas				14. MOTHER'S MAIDEN NAME: Mary Barnaskis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) WW-11 217-16-8673		17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 600.0 CHRONIC PYELONEPHRITIS							9 YEARS
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 6, 1955, to April 24, 1955, that I last saw the deceased alive on XXXXXX 1955 and that death occurred at 2:10 PM. from the causes and on the date stated above.							
SIGNATURE WILLIAM R. VANDEGRIET, M.D.		ADDRESS M. D. VAH, Fort Howard, Maryland		DATE SIGNED 4-25-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 27, 1955		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE ✓		24. FUNERAL DIRECTOR William Cook Blight, Inc. Funeral Home		ADDRESS 6009 Harford Road, Baltimore 14, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

3491

03478
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 12 Film 181 5-9-55 et

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		CITY (If outside corporate limits, write RURAL and give nearest town) Parkville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7610 Old Harford Road		STREET ADDRESS (If rural, give location) 7610 Old Harford Road	
3. NAME OF DECEASED (Type or Print) Mr. Thomas Paton Thornton		4. DATE OF DEATH (Month) April (Day) 30th (Year) 1955	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Jan. 5, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long Shoreman		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Thornton		14. MOTHER'S MAIDEN NAME Winnie Brannan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. 216-10-5919	
17. INFORMANT AND ADDRESS Mrs. Jean E. Thornton, 7610 Old Harford Rd.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1991 Immediate cause (a) Generalized abdominal carcinoma				3 mos	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION 1/31/55		19b. MAJOR FINDINGS OF OPERATION Generalized carcinoma		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1/24**, 19**55**, to **4/30**, 19**55**, that I last saw the deceased alive on **4/30**, 19**55**, and that death occurred at **3:40** p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE **May 3rd, 1955** NAME OF CEMETERY OR CREMATORY **Moreland Memorial Park** LOCATION (City, town, or county) (State) **Baltimore, Maryland**

DATE REC'D BY LOCAL REG. **5-5-55** REGISTRAR'S SIGNATURE24. FUNERAL DIRECTOR **Leonard J. Ruck, 5305 Harford Road #14** ADDRESS

Dr. Harry Connolly

13 E. Eager VE 7 7447 -2 T04

5221 Springlake Way HO 7 7150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE CO.</u> MARYLAND				STATE <u>MD.</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>DUNDALK</u>				CITY (If outside corporate limits write RURAL and give nearest town) <u>DUNDALK (22)</u>			
TOWN <u>DUNDALK</u>				TOWN <u>DUNDALK (22)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 DETROIT AVE.</u>				STREET ADDRESS (If rural, give location) <u>201 DETROIT AVE.</u>			
3. NAME OF DECEASED:		(First) <u>NICK</u>		(Middle) <u>VITO</u>		(Last) <u>TINELLI, JR.</u>	
(Type or Print)						4. DATE OF DEATH	
						Month <u>4</u> Day <u>17</u> Year <u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:		IF UNDER 1 YEAR	
<u>M</u>	<u>W</u>		<u>Feb. 7, 1955</u>	yrs. <u>2</u> Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>N. V. TINELLI, SR.</u>				<u>PATRICIA MALONE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
				<u>NICK V. TINELLI, SR. - #2 ABOVE</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>ACUTE PURULENT OTITIS MEDIA</u>					
DUE TO <u>BILATERAL</u>					
Antecedent cause(s) (b) <u>giving rise to the above cause</u>					
DUE TO <u>stating underlying cause last</u>					
(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?	
				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<u>R. B. Fisher</u>		DEPUTY MEDICAL EXAMINER		<u>4/17/55</u>	
		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>4-20-55</u>		<u>OAK LAWN</u>	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR		ADDRESS	
<u>BALTO. Co. MD.</u>		<u>William M. Kelly</u>		<u>Walter Burke Bradley, Dundalk, MD.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			
<u>April 19-1955</u>		<u>William M. Kelly</u>			
<u>2025222385</u>					

RECEIVED

APR 21 1965

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03480

3492

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
TOWN <u>Carney</u>		TOWN <u>Carney</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9800 Magledt Ave</u>		STREET ADDRESS (If rural, give location) <u>9800 Magledt Ave Balto 34</u>	
3. NAME OF DECEASED (Type or Print) <u>Nabel F Trout</u>		4. DATE OF DEATH <u>April 16 1955</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Jan 9-1922</u>	
9. AGE last birthday <u>33 yrs.</u>		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN. Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Co md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence E Blakely</u>		14. MOTHER'S MAIDEN NAME <u>Anna E. Tinn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>Mr John Trout 9800 Magledt Ave</u>	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

175X Immediate cause (a) Carcinomatosis

Antecedent cause(s) (b) Carcinoma of ovaries bilateral

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov, 1954, to April 16, 1955, that I last saw the deceased alive on April 16, 1955, and that death occurred at 1:30 p m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/19/55</u>	NAME OF CEMETERY OR CREMATORY <u>Morland Memorial Park</u>	LOCATION (City, town, or county) <u>Balto md</u>	(State)
DATE REC'D BY LOCAL REG. <u>4-18-55</u>	REGISTRAR'S SIGNATURE <u>A W Hedgcock</u>	24. FUNERAL DIRECTOR <u>Lassalle Funeral Home 7401 Belair Rd</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11 E. Chase St 1-5 PM.

Dr. Diehl

Sa 7-4787

03481

3493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rodgers Forge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rodgers Forge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>206 Dunkirk Road</u>		STREET ADDRESS (If rural, give location) <u>206 Dunkirk Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Gertrude Lovett Underwood</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 3, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>May 10, 1873</u>
9. AGE last birthday <u>81</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Lovett</u>		14. MOTHER'S MAIDEN NAME <u>Tabitha Cross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Miss Ethel S. Underwood 206 Dunkirk Road</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
592X Immediate cause (a) <u>Cerebral Hemorrhage</u>		
Antecedent cause(s) (b) <u>Hypertension, Chronic Nephritis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) <u>Cardiac Insufficiency</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1954 to Apr. 3, 1955, that I last saw the deceased alive on Apr. 3, 1955, and that death occurred at 10 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 6, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>
DATE REC'D BY LOCAL REG. <u>4-6-54</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>	ADDRESS <u>3631 Falls Road</u>

Norace F. Burgee

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



03482

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3494

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Owings Mills</u>		<u>20 yrs</u>		TOWN <u>Owings Mills</u> <input checked="" type="checkbox"/>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Timber Grove Road</u>				STREET ADDRESS (If rural give location) <u>Timber Grove Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>Robert</u> <u>Clinton</u> <u>Utz</u>				OF DEATH: <u>April</u> <u>29</u> <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>		8. DATE OF BIRTH: <u>Apr 17 1878</u>	
				9. AGE last birthday <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
13. FATHER'S NAME: <u>Robert O Utz</u>				14. MOTHER'S MAIDEN NAME: <u>Hontas Vautis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-09-8874</u>		17. INFORMANT & ADDRESS: <u>Mrs Lucy Lee Utz Owings Mills Md</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>few d</u>	
ANTECEDENT CAUSE (B) <u>Hypertension</u>						<u>few yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Atherosclerosis</u>						<u>few yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19A. DATE OF OPERATION: <u>✓</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>1-1-53</u> , to <u>4-29-55</u> , that I last saw the deceased alive on <u>4-10-55</u> , and that death occurred at <u>9:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James H. Saffell</u>		M. D. <u>Reisterstown Md</u>		ADDRESS <u>4-29-55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 2 1955</u>		NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>		LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-30-55</u>		REGISTRAR'S SIGNATURE <u>James B. Shive</u>		24. FUNERAL DIRECTOR ADDRESS <u>Wm Berryman & Sons Reisterstown Md</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

45-20-4214

RECEIVED
MAY 3 1965
BUREAU V. 2

3495

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03483

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cowings Mills</u>		STATE <u>Md.</u> COUNTY <u>Prince George</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
TOWN <u>Cowings Mills</u>		LENGTH OF STAY (in this place) <u>7 mos</u>		OR TOWN <u>Hyattsville</u>		STREET ADDRESS (If rural, give location) <u>8109 140th Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood State Training School</u>							
3. NAME OF DECEASED: (First) <u>Robert</u> (Middle) <u>J. Jr.</u> (Last) <u>Vaughan</u>				4. DATE OF DEATH: (Month) <u>4</u> (Day) <u>15</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Wt.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S.</u>		8. DATE OF BIRTH: <u>8/24/54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: yrs. <u>8</u>		11. BIRTHPLACE (State or foreign country): <u>U. S. A.</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME: <u>Robert Thomas Vaughan</u>				14. MOTHER'S MAIDEN NAME: <u>Jane Theresa Epps</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Ceiphyreration (food aspiration)</u>							
Antecedent cause(s) (b) <u>Chronic Brain Congenital (Microcephaly)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (c) <u>Amniontal Deficiency</u>							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>4/16/55</u> 19b. MAJOR FINDINGS OF OPERATION: <u>Respiratory tract obstruction</u>							
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT <input checked="" type="checkbox"/> (Specify) <u>HOMICIDE</u>				PLACE (Home, farm, factory, street, office bldg., etc.) <u>Cowings Mills, Baltimore, Md.</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
				HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/14</u> , 19 <u>55</u> , to <u>4/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/15</u> , 19 <u>55</u> , and that death occurred at <u>9:30 p.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wesley B. Johns</u>				(DEGREE OR TITLE) ADDRESS <u>U. D. Rosewood State Training School</u>		DATE SIGNED <u>4-16-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>4/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>ST MARY'S</u>		LOCATION (City, town, or county) (State) <u>FAIRFAX Station, VA</u>	
DATE REC'D BY LOCAL REG. <u>4/16/55</u>		REGISTRAR'S SIGNATURE <u>Marion E. Newell</u>		24. FUNERAL DIRECTOR <u>Everly Funeral Home</u> ADDRESS <u>FAIRFAX, VA</u>			

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

APR 22 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803484

3496

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL or and give nearest town) <i>Ellicott City (Rural)</i>	LENGTH OF STAY (in this place) <i>17 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City (Rural)</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Westchester Avenue</i>		STREET ADDRESS (If rural give location) <i>Westchester Avenue</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>ROYAL</i>	(Middle) <i>EDWARD</i>	(Last) <i>WALL</i>	(Month) <i>April</i> (Day) <i>10</i> (Year) <i>1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>Feb. 22, 1902</i>
9. AGE last birthday <i>53</i> yrs.		10. IF UNDER 1 YEAR: Months <i>1</i> Days <i>10</i> Hours <i>10</i> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Guard</i>		12. KIND OF BUSINESS OR INDUSTRY: <i>Industrial</i>	
13. BIRTHPLACE (State or foreign country): <i>Maryland</i>		14. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
15. FATHER'S NAME: <i>John C. Wall</i>		16. MOTHER'S M maiden NAME: <i>Martha A. Litchfield</i>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <i>No</i>		18. SOCIAL SECURITY NO. <i>217-01-4135</i>	
19. INFORMANT & ADDRESS: <i>Mrs. Royal E. Wall</i>		<i>Westchester Ave. Ellicott City, Md.</i>	
19. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>			<i>1 1/2 hours</i>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Cirrhosis of Liver.</i>			<i>2 years.</i>
DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>None</i>		19B. MAJOR FINDINGS OF OPERATION: <i>None</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>Jan. 1, 1953</i> to <i>4/10, 1955</i> that I last saw the deceased alive on <i>Oct. 1, 1954</i> , and that death occurred at <i>9 P. M.</i> from the causes and on the date stated above.			
SIGNATURE <i>George E. Bunting</i>		DATE SIGNED <i>4/11/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Apr. 14, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>		LOCATION (City, town, or county) (State) <i>Ellicott City, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4/13/55</i>		REGISTRAR'S SIGNATURE <i>V.E. Harris</i>	
24. FUNERAL DIRECTOR <i>Easton Sons</i>		ADDRESS <i>Catonsville 28, Md.</i>	

RECEIVED

APR 15 1955

BUREAU V. S.

3497 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 103485
CERTIFICATE OF DEATH Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland COUNTY Balto.			
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN Catonsville		LENGTH OF STAY (in this place) 1 year		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Halethorpe			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (If rural give location) Second Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last) Charles Henry Walshe				4. DATE (Month) (Day) (Year) OF DEATH April 2, 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 6/30/1897	9. AGE last birthday 57	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked		10B. KIND OF BUSINESS OR INDUSTRY: none		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Edward C. Walshe				14. MOTHER'S MAIDEN NAME: Elizabeth Briggs			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. none own		17. INFORMANT & ADDRESS: Mr. Robert J. Walshe - 615 Wilton Rd.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Lobar pneumonia							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
Chronic arteriosclerotic heart disease years							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-24- , 19 54 to 4-2- , 19 55 , that I last saw the deceased alive on 4-2- , 19 55 and that death occurred at 7:10 a.m. from the causes and on the date stated above.							
SIGNATURE <i>Frederick E. Phillips</i>		ADDRESS Spring Grove State Hospital		DATE SIGNED 4-4-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/5/55		NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		LOCATION (City, town, or county) Woodlawn, Md.	
DATE REC'D BY LOCAL REGISTRAR 5-5-55		REGISTRAR'S SIGNATURE <i>G. W. Fredrick</i>		FUNERAL DIRECTOR <i>Wm. G. Dickner</i>		ADDRESS <i>Sons-Bald</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

RECEIVED
BUREAU OF PLANT INDUSTRY
U. S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

3498

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03486

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>		STREET ADDRESS (If rural, give location) <u>10 Dixie Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>J.</u> (Middle) <u>Edwin</u> (Last) <u>Warwick</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>26</u> , <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 16, 1894</u>
9. AGE last birthday <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice President Baltimore Elec. Sup. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Warwick</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hild</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>10 100 000 000</u>	
17. INFORMANT <u>Mrs. J. Edwin Warwick 10 Dixie Dr. Towson, Md.</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
141X Immediate cause (a) <u>Carcinoma of the tongue</u>	<u>1 yr</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	
(b) _____	
(c) _____	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 26, 1955, to Apr. 26, 1955, that I last saw the deceased alive on _____, 19_____, and that death occurred at 11:45 A. m., from the causes and on the date stated above.

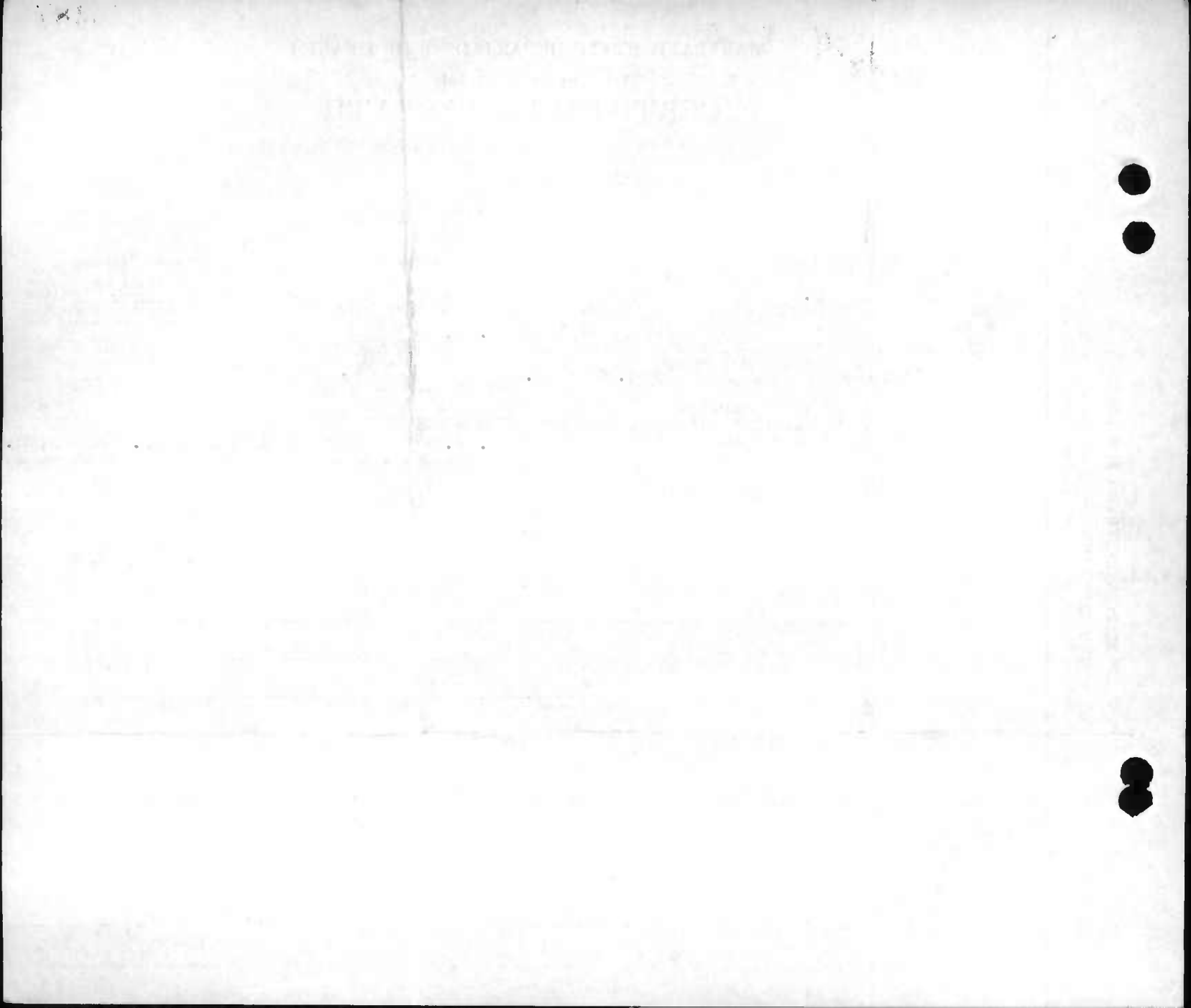
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

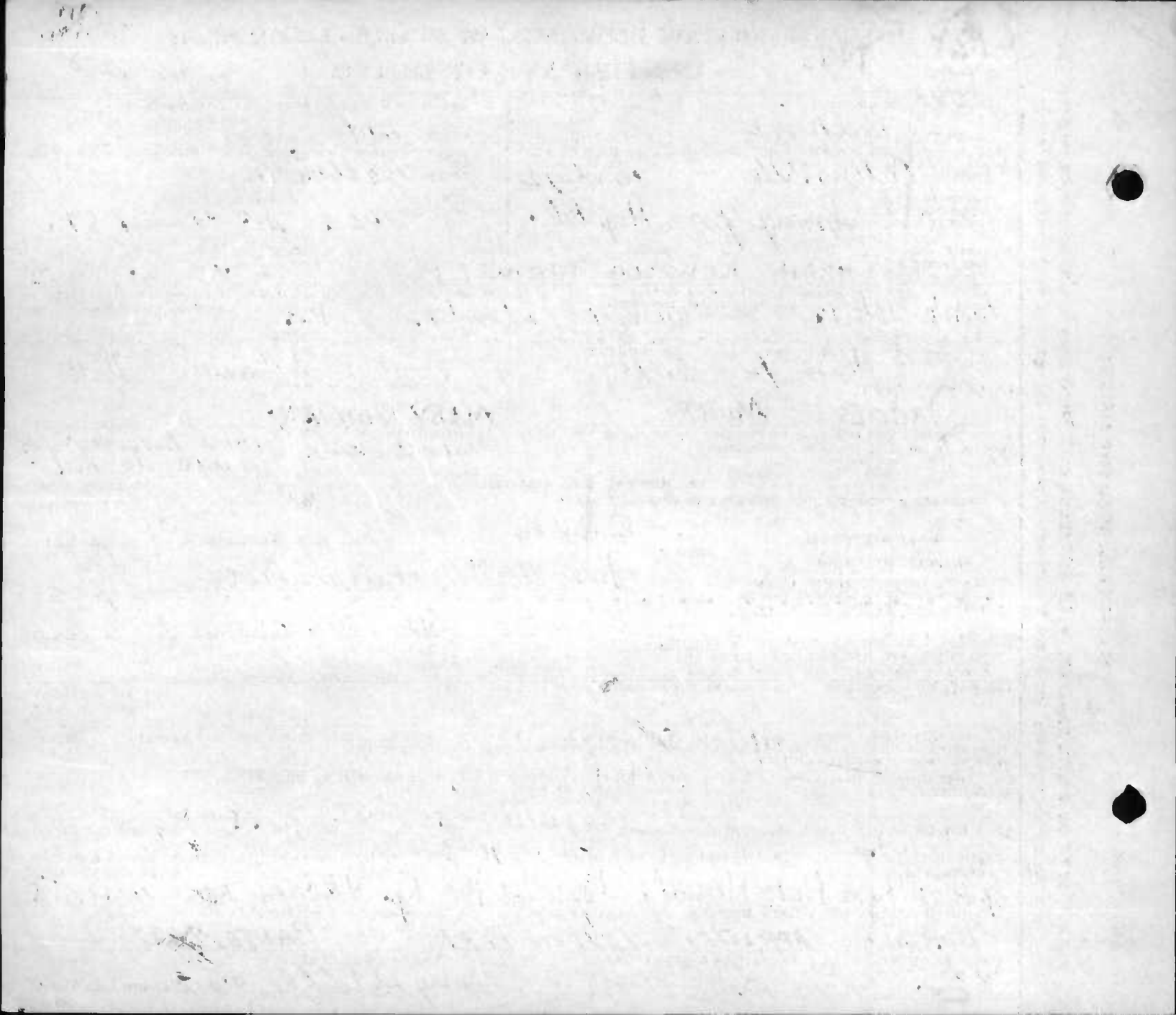


PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03487
3499 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md</i>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>52 Catonsville</i>	LENGTH OF STAY (in this place) <i>10 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	<i>3401-4</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>14 Spring Grove Hospital</i>		STREET ADDRESS (If rural give location) <i>1403 Mc Henry St.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>SARAH REBECCA WEAVER</i>		OF DEATH: <i>4 21 1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>2/20/72</i>
9. AGE last birthday <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housework</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>O.H.</i>	11. BIRTHPLACE (State or foreign country): <i>(U.S.A.) Indiana</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME: <i>JACOB MURR</i>	
14. MOTHER'S MAIDEN NAME: <i>MARY WEIGNER?</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Margaret Evans 1404 Inverness Ave Balto 30 Md</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
260X IMMEDIATE CAUSE (A) <i>Senility</i>			<i>year</i>
ANTECEDENT CAUSE (S) DUE TO <i>Generalized Arteriosclerosis</i>			<i>year</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Diabetes Mellitus.</i>			<i>years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <i>4/11</i> , 19 <i>55</i> , to <i>4/21</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4/21</i> , 19 <i>55</i> , and that death occurred at <i>10:50 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Spring Grove State Hospital, Catonsville, Md. by Dr. Crown</i>		DATE SIGNED <i>4/21/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>APR 20/55</i>	
NAME OF CEMETERY OR CREMATORY <i>LODGEON PARK</i>		LOCATION (City, town, or county) (State) <i>BALTO. M.D.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4-25-55</i>		REGISTRAR'S SIGNATURE <i>Harry H. Whitte</i>	
24. FUNERAL DIRECTOR		ADDRESS <i>4101 EDMONDSON AVE</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3590
CERTIFICATE OF DEATH

03488

Reg. Dist. No. 5/

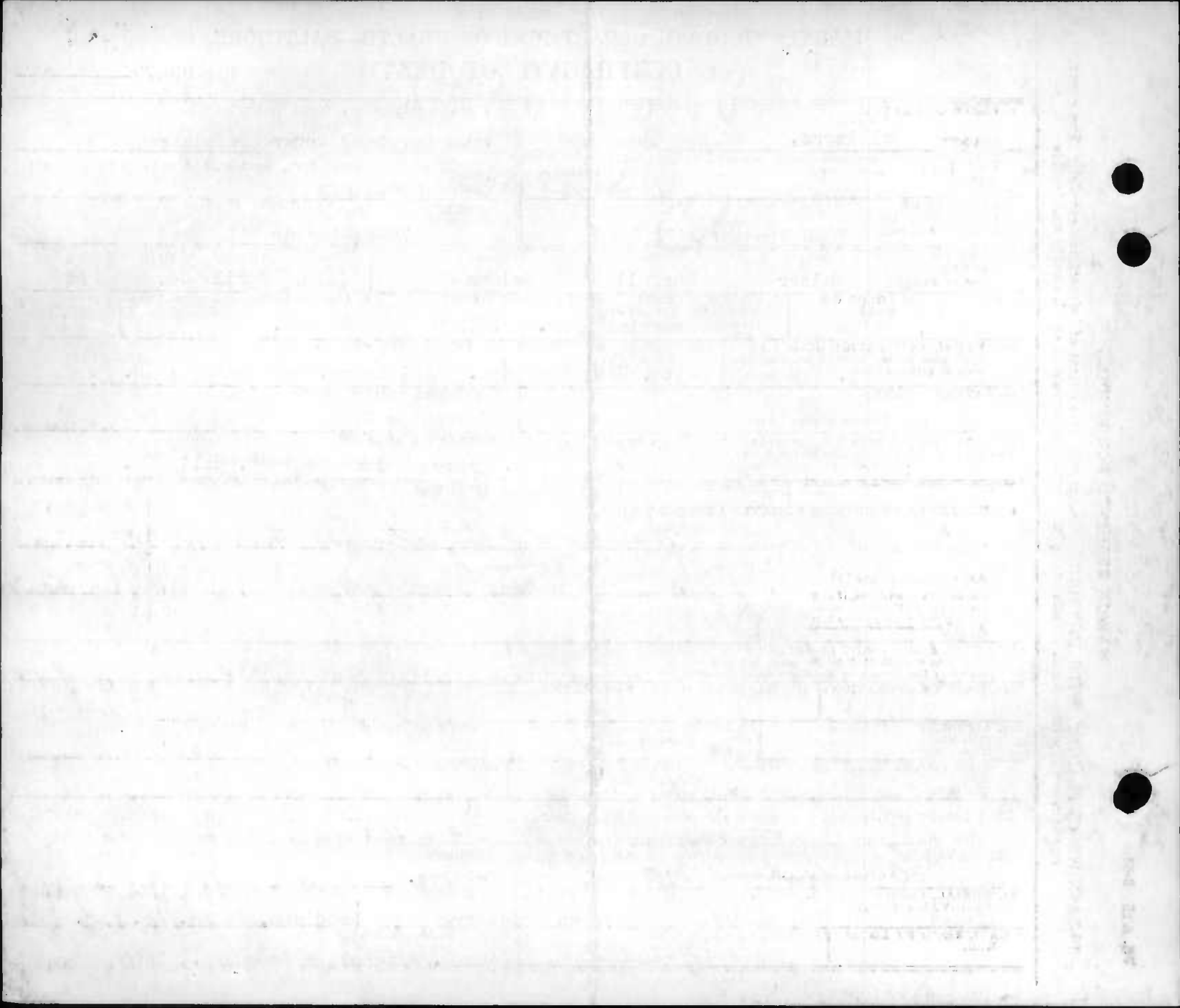
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore,		MARYLAND		STATE Maryland COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Woodlawn		1 yr.		TOWN Woodlawn X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7036 Windsor Mill Road				STREET ADDRESS (If rural, give location) 7036 Windsor Mill Road			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)			
Walter Russell Welden				April 30, 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
Male	White	married	Feb. 12, 1889	66 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Fireman				10b. KIND OF BUSINESS OR INDUSTRY: Balto. City Fire Dept.		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	
13. FATHER'S NAME: William Thomas Welden				14. MOTHER'S MAIDEN NAME: Josephine V. Hall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mr. George Welden 2124 Mt. Holly St.	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
(a) Immediate cause DUE TO Malignant Hypertension & Hemia				2 years	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO				6 mos.	
(c)					
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None					
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> M.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July , 19 43 , to April 30 , 19 55 , that I last saw the deceased alive on April 29 , 19 55 , and that death occurred at 6 A. m., from the causes and on the date stated above.					
SIGNATURE Sam Ashman M.D.		(DEGREE OR TITLE) M.D.		ADDRESS 5907 Gwynn Oak Ave.	
23. BURIAL, CREMATION REMOVAL (Specify): Burial		DATE THEREOF May 3, 1955		NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.		24. FUNERAL DIRECTOR ADDRESS John O. Mitchell & Sons Inc., 1900 Eutaw Pl.			
DATE REC'D BY LOCAL REG. 5-2-55		REGISTRAR'S SIGNATURE aw Ashman			

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3501

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>D.C.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>520 Catonsville</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Annapolis Junction</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Caton Ridge Nursing Home</i>				STREET ADDRESS (If rural give location) <i>13X-2V</i>			
3. NAME OF DECEASED: (Type or Print) <i>Sarah Eliza Welsh</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>April 16 1955</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widowed</i>	8. DATE OF BIRTH: <i>Feb. 14 1868</i>	9. AGE last birthday: <i>87 yrs.</i>	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Own home</i>		11. BIRTHPLACE (State or foreign country): <i>C. D. Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Charles Walter Owens</i>				14. MOTHER'S MAIDEN NAME: <i>Laura Virginia Halyb</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No.: <i>—</i>		17. INFORMANT & ADDRESS: <i>Mr. Frederick Owens, Annapolis Junction, Maryland</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
422.1 Immediate cause (a) <i>Acute & Chronic Congestive Heart Failure</i>							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Arteriosclerosis Generalized Degenerative Myocarditis.</i>							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 1 1953</i> to <i>16 April 1955</i> , that I last saw the deceased alive on <i>14 April 1955</i> , and that death occurred at <i>2:51 PM</i> from the causes and on the date stated above.							
SIGNATURE <i>Dr. H. G. A. D.</i>		(Degree or title)		ADDRESS <i>1707 Edmondson Ave Catonsville Md</i>		DATE SIGNED <i>18 April 55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>April 19 1955</i>		<i>Garage Cemetery</i>		<i>Garage, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>Apr 19 1955</i>		<i>Victor E. Barry</i>		<i>De Witt Donaldson, Laurel, Md.</i>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 22 1955

RECEIVED

03490

MARYLAND STATE DEPARTMENT OF HEALTH

3592

CERTIFICATE OF DEATH

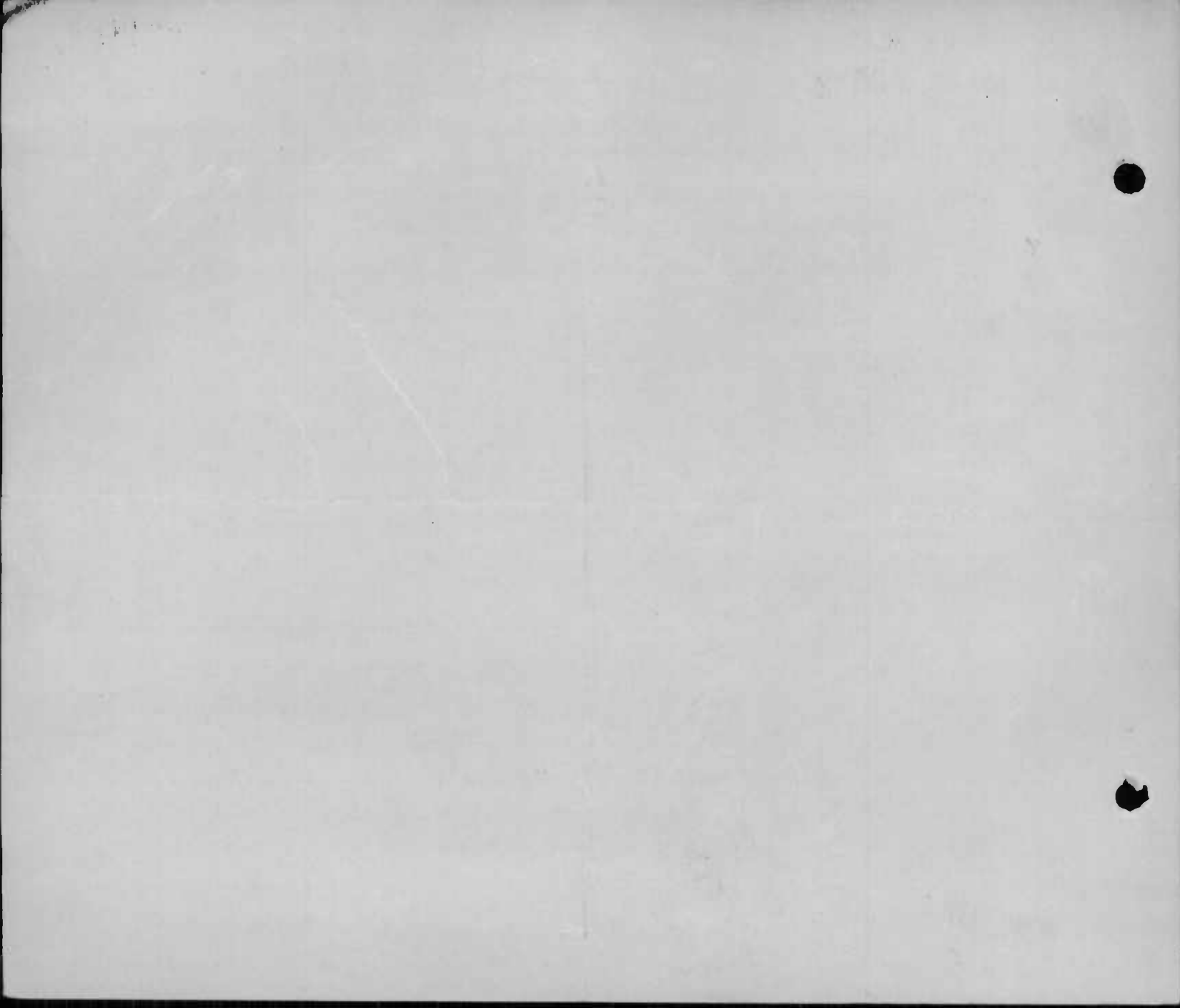
FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY BALTO		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON		CITY (If outside corporate limits, write RURAL and give nearest town) (RURAL) COCKEYSVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS STATE TEACHERS COLLEGE		STREET ADDRESS (If rural, give location) 1 MI. NR. OF COCKEYSVILLE	
3. NAME OF DECEASED (Type or Print)	(First) JOE	(Middle) YOUNG	(Last) WEST
4. DATE OF DEATH	(Month) Apr.	(Day) 29	(Year) 1955
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH JAN. 3, 1904
9. AGE last birthday 51 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER	11. BIRTHPLACE (State or foreign country) MISSISSIPPI	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME JOSEPH J. WEST	14. MOTHER'S MAIDEN NAME LILY BROWNING	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 218-34-1138	17. INFORMANT AND ADDRESS PAUL M. WEST SPARKS, MD.	18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause (a) Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH Sudden
Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE Charles + O'Donnell MD		DATE SIGNED 4/29/55	
DEGREE OR TITLE		ADDRESS 7501 Yach Rd Towson 4 MD	
23. REMOVAL (Specify) ENTOMBMENT	DATE THEREOF 5-2-1955	NAME OF CEMETERY OR CREMATORY LOBBRAINE PARK	LOCATION (City, town, or county) (State) BALTO. MD.
DATE REC'D BY LOCAL REG. 5-2-55	REGISTRAR'S SIGNATURE aw Hedrick	24. FUNERAL DIRECTOR H. W. JENKINS & SONS CO 4905 YORK ROAD BALTO. 12 MD.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3593

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803491

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 22, Film 180 4-22-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Pennsylvania		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
Fort Howard		147 Days		York			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 133 West King Street			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
STEWART C. WHITE				April 12 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Single	12/29/11	43 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
Bus Driver		Grey Hound		Keymar, Maryland		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
James C. White				Clara Zent			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
Yes		204 05 1202		Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) MYELOID METAPLASIA OF SPLEEN							
ANTECEDENT CAUSE (S) DUE TO UNKNOWN							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION:				20. AUTOPSY?	
2-18-55		Splenectomy Dg. Myeloid Metaplasia of spleen				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3031-33		Exploratory Laparotomy - No surgical disease found					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
VA M.				12			
22. I hereby certify that I attended the deceased from Nov. 17, 1954 , to April 13, 1955 , and that death occurred at 5:10 PM , from the causes and on the date stated above.							
SIGNATURE William B. VandeGrift, M.D.				DATE SIGNED April 13, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		APR. 13, 1955		Mt. Rose Cemetery		York, Pennsylvania	
DATE REC'D BY LOCAL REGISTRAR SIGNATURE				24. FUNERAL DIRECTOR ADDRESS			
1955				Wm. Cook-Bright Funeral Home, Inc.			
SHIPPED TO: E. Market Street, York, Pennsylvania				0009 Harford Road, Baltimore 14, Md.			

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 20 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803492

3524

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>268 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>4439 Pen Lucy Road</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>JAMES</u>		(Middle) <u>R.</u>		(Last) <u>WHITEHILL</u>	
4. DATE OF DEATH		(Month) <u>April</u>		(Day) <u>24,</u>		(Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>2-6-93</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Cutter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Liberty Food Markets</u>		11. BIRTHPLACE (State or foreign country): <u>Unionville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John W. Whitehill</u>				14. MOTHER'S MAIDEN NAME: <u>Susan Barnes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>WW-1 220-05-5372</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>602x</u>						<u>9 Months</u>	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>STRICTURE AND FISTULA OF LEFT URETER WITH PYONEPHROSIS</u>							
(B) <u>RIGHT NEPHRECTOMY</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						13 Years	
19A. DATE OF OPERATION: <u>1. 7-8-54, 2. 12-20-54, 3. 4-4-55, 4. 4-12-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>1. Ureterolithotomy; left; 2. Ureteroplasty, left; 3. Ureteroneocystostomy; 4. Closure of Wound Dehiscence</u>		19C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> attended the deceased from <u>July 30, 1954, to April 24, 1955</u> , that I last saw the deceased <u>and that death occurred at 3:10 PM, from the causes and on the date stated above.</u>							
SIGNATURE <u>William B. Vandegrift, M.D.</u>		ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>4-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8-27-55</u>		REGISTRAR'S SIGNATURE <u>Dr. Hedrick</u>		24. GENERAL DIRECTOR <u>Harry A. Witzke</u>		ADDRESS <u>4101 Edmondson Avenue, Baltimore, Md.</u>	

UNITED STATES DEPARTMENT OF HEALTH - NATIONAL BUREAU OF HEALTH

Form with multiple sections and fields, including checkboxes and text areas. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise. The text is mostly illegible due to the rotation and low contrast.

Vertical text on the right margin, likely a date or reference number, oriented vertically.

Handwritten notes or signatures at the bottom right of the page.

3505

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03493

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. NAME OF DECEASED (Type or Print) JAMES M. WILLIAMS			2. DATE OF DEATH April 22, 1955		
3. PLACE OF DEATH: A. Baltimore City, Maryland 2507 Wentworth Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore County - Parkville - 14			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 2507 Wentworth Road					
c. Length of stay in Baltimore 68 Years		Yrs. Mos. Days			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH March 17, 1872	
9. AGE (In years last birthday) 83		10. Under 1 Year Months: Days		11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10B. KIND OF BUSINESS OR INDUSTRY American Stores Co.		
11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME (unknown) Williams			14. MOTHER'S MAIDEN NAME George White		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. 217 -05-1624		
17. INFORMANT Mrs. Rebecca E. Williams			ADDRESS 2507 Wentworth Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cancer of Stomach			INTERVAL BETWEEN ONSET AND DEATH 1 year		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Scuitly					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY None		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from April 22, 1955 to April 22, 1955		23. I certify that (I) (we) last saw the deceased alive on 4-19-55 , and that death occurred at 10:45 A.M. m., from the causes and on the date stated above.	
23A. SIGNATURE Dr. J. J. Gandy		23B. ADDRESS 5106 Harford Road		23C. DATE SIGNED 4-23-55	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE April 25, 1955		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Baltimore Co. Maryland		24E. FUNERAL DIRECTOR Wm. Cook - Blalston		ADDRESS 6009 Harford Road	
DATE RECEIVED BY LOCAL REGISTRAR APR 25 1955		REGISTRAR'S SIGNATURE Wm. Cook		25. FUNERAL DIRECTOR ADDRESS 6009 Harford Road	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED

APR 26 1955

BUREAU V. S.

31

Reg. Dist. No.....

3506

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH - COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Woodlawn		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR Woodlawn	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7007 Windsor Mill Road				STREET ADDRESS (If rural, give location) 7007 Windsor Mill Road.	
3. NAME OF DECEASED (First) HORACE (Middle) VERNON (Last) WINDSOR		4. DATE OF DEATH April, 1st 19 55			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 22nd 1877	9. AGE last birthday 77 yrs.	If under 1 year Months Days Hours Mins. If under 24 hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Pattern Maker		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Howard Co. Maryland	
13. FATHER'S NAME William Brewer Windsor		14. MOTHER'S MAIDEN NAME Harriet E. Dudrow		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY No. 212-10-4946		17. INFORMANT AND ADDRESS Mrs. H. Vernon Windsor 7007 Windsor Mill Rd.	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) Coronary Thrombosis					24 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardiovascular Disease					5 years
(c) Senility					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION No operation					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 25 , 19 54 , to April 1 , 19 55 , that I last saw the deceased alive on April 1 , 19 55 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above.					
SIGNATURE Joshua H. Armacost MD.		ADDRESS 6419 Windsor Mill Rd Baltimore 7 Md		DATE SIGNED 4-2-55	
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE THEREOF April, 4th 1955		NAME OF CEMETERY OR CREMATORY MT. OLIVE CEMETERY	
DATE REC'D BY LOCAL REG. 4-4-55		REGISTRAR'S SIGNATURE John H. ...		FUNERAL DIRECTOR Willis L. ... ADDRESS 4510 Liberty Heights Ave	

